Sea Mills Surgery

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 Sea Mills Surgery on 21 July 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. However we found the practice required improvement for providing safe services. It was also rated as good for providing services for all of the population groups.

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.
- 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 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.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- The practice facilities were designed and equipped to meet patients' treatment needs.
- Information about how to complain was available and easy to understand.

Summary of findings

- Appointments were not limited by 10 minute slots and were able to use their clinical judgements to book appropriate length of appointments for patients.
- The systems and processes intended to keep the service safe were not always fully implemented, for example, the practice had information about infection control audits not completed an infection control audit and we found a number of areas where the risk of infection had not been assessed and remedial action put into place.

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

Importantly the provider must:

- Comply with the guidance from the Department of Health, Code of Practice on the prevention and control of infections and related guidance.
- Systems to assess, monitor and improve the quality and safety of the service must be improved particularly in areas such as fire safety and regular maintenance.

In addition the provider should:

- Ensure that staff training is recorded centrally so that the practice can easily demonstrate staff had the skills to meet patient needs.
- Ensure that, where applicable, the professional registration of staff is checked and a record kept of the current registration.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. But the systems and processes intended to keep the service safe were not always fully implemented, for example, the practice had not completed an infection control audit. We also found there was no established system to assess and monitor the service for quality and safety such as fire safety.Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook audits to monitor appropriate prescribing of medicines. We found staff had the skills, knowledge and experience to deliver care and treatment and had undertaken additional training to support this.

Are services caring?

Good

The practice is rated as good for providing caring services. We observed a strong patient-centred culture. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. Patients told us they were treated as individuals and partners in their care. We found the practice routinely identified patients with caring responsibilities and supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. We found urgent and routine appointments were available the same day. 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?

Good

The practice is rated as good for being well-led. The recently established partnership had a new vision planned for the practice. There was a clear leadership structure and staff said they felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place for clinical governance. The practice proactively sought feedback from staff and patients, which it acted on. 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. 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, emergency admission avoidance. Patients over 75 had a named GP. We found integrated working arrangements with community teams. The practice worked closely with carers and one staff member acted as the carer's champion.

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. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly nurse led clinics were available to patients diagnosed with long term conditions such as diabetes. Longer appointments and home visits were available when needed. All of these patients had a structured annual review to check their health and medicines needs were being met. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choices and decisions with other service providers.

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. Appointments were available outside of school hours and the premises were suitable for children and babies, with a specific room available for breast feeding mothers. There was joint working with midwives, health visitors and school nurses. The practice worked to provide inclusive services for younger patients, such as having the public health chlamydia screening service based at the practice and operating the 4YP (4 young people) initiative which enabled young people to easily access a GP consultation.

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered unlimited access to GPs for telephone consultations; appointment need was audited and usage predicted which allowed for adjustment in the number of pre-bookable appointments available.

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. They held a register of vulnerable patients such as those with a learning disability. The practice offered 'familiarisation sessions' for patients with learning disabilities to enable them to be confident to attend the practice for appointments. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Patients could access additional services onsite such as substance misuse services.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients with serious mental illness had care plans which included indicators of relapse to support patients to seek help. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as talking therapies, and the 'Off The Record' service for young patients who experienced mental health difficulties. The practice could access a pathway navigator and specialist nurse for patients living with dementia.

Summary of findings

What people who use the service say

We spoke with patients visiting the practice and we received 26 comment cards from patients who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey.

The patient survey data showed:

- 87% of respondents found it easy to get through to the practice by phone
- 94% of respondents found the receptionists at this practice helpful
- 68% of respondents with a preferred GP usually get to see or speak to that GP
- 89% of respondents were able to get an appointment to see or speak to someone the last time they tried
- 98% of respondents said the last appointment they got was convenient
- 81% of respondents described their experience of making an appointment as good

These results are better than the average for Bristol Clinical Commissioning Group.

We read the commentary responses from patients and noted they included observations such as:

- Patients found it easy to make appointments.
- Patients told us GPs explained treatment and listened to them.
- Patients felt staff were considerate, kind and caring.
- Patients felt they were treated with dignity and respect
- Patients felt they were offered an excellent practice
- There was confidence expressed by patients about the practice.

During our inspection we also spoke with four patients; the comments made by patients were very positive and praised the care and treatment they received. For example, patients had commented positively about being involved in the care and treatment provided, and feeling confident in their treatment.

The practice had a virtual patient representation group (PRG) of approximately 30 patients which had limited involvement and impact in the practice. The gender and ethnicity of group was not representative of the total practice patient population, however the group was widely advertised and information about the group was available on the website and in the practice. The practice had found it challenging to engage patients in the PRG however the practice were planning a relaunch to attract new members.

The practice had also commenced their current 'friends and family' survey which was available in a paper format placed in the reception area and online. The results of the survey up to 31 May 2015 indicated that 100% of patients would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Comply with the guidance from the Department of Health, Code of Practice on the prevention and control of infections and related guidance.
- Systems to assess, monitor and improve the quality and safety of the service must be improved particularly in areas such as fire safety and regular maintenance.

Action the service SHOULD take to improve

- Ensure that staff training is recorded centrally so that the practice can easily demonstrate staff had the skills to meet patient needs.
- Ensure that, where applicable, the professional registration of staff is checked and a record kept of the current registration.

Sea Mills Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a nurse specialist advisor.

Background to Sea Mills Surgery

Sea Mills Surgery is located in an urban area of North Bristol. They have approximately 6400 patients registered.

The practice operates from one location:

Sea Mills Surgery,

2 Riverleaze,

Sea Mills,

Bristol, BS9 2HL

It is sited in a purpose built two storey building. The consulting and treatment rooms for the practice are situated on the ground floor. There is limited patient parking immediately outside of the practice with spaces reserved for those with disabilities.

The practice is made up of four GP partners and three salaried GPs working alongside qualified nurses and health care assistants. The practice is open on Monday to Friday 8am – 6.30pm for on the day urgent and pre-booked routine GP and nurse appointments.

The practice has a Personal Medical Services contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice is contracted for a number of enhanced services including extended hours access, facilitating timely diagnosis and support for patients with dementia, minor surgery, patient participation, immunisations and remote care monitoring.

The practice is a training practice for doctors who were training to be qualified as GPs, one partner acts as a trainer. Patients seen by these GPs are given longer appointments and the trainee has access to a senior GP throughout the day for support.

The practice does not provide out of hour's services to its patients, this is provided by BrisDoc. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years old: 5.8%

5-14 years old: 11.6%

Under 18 years: 14.9%

65-74 years old: 22.1% - higher than the national England average.

75-84 years old: 11.6% - higher than the national England average.

85+ years old: 4% - higher than the national England average.

Information from NHS England indicates the practice is in an area of medium deprivation with a much higher than national average number of patients with long standing health conditions, a higher than average number of patients in nursing homes and lower than average levels of paid work. The practice population is stable with several family generations of patients registered at Sea Mills Surgery.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 July 2015. During our visit we spoke with a range of staff including GPs, nurses, reception and administrative staff and the management team, and spoke with patients who used the service. We observed how patients were being cared for and talked with carers and/or family members and reviewed anonymised treatment records of patients.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record.

We saw records of training which indicated staff were trained to a level of competence which kept patients safe. National patient safety alerts and other safety guidance was checked and circulated to the relevant staff by the practice manager or partners.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents or events. We read minutes of meetings which evidenced that the above information was recorded and reviewed by the partners at the practice to prevent recurrence.

Learning and improvement from safety incidents.

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event was analysed and discussed by the GPs, nursing staff and senior practice management. For example, we read about an event where a patient had phoned with specific symptoms. The receptionist had spoken to the duty GP but it was not identified as a 'red-flag issue' until the patients attended for an appointment later in the day. We found the recording of events was brief and not always clear if the practice had put actions in place in order to minimise or prevent reoccurrence of events.

When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role.

Staff reiterated to us that promoting and improving the service for patients was their primary concern. We were told how all staff were encouraged to participate in learning and to improve safety as much as possible and this meant they were confident to report concerns when things went wrong. For example, we observed that all members of staff were invited to attend the clinical governance meetings.

We also looked at accident and incident records and saw that incidents had been recorded and if needed escalated to significant events. Safety alerts and information relating to patients was available on the electronic records for staff to readily access.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. We were told that all non-clinical staff at the practice had been provided with training for safeguarding children. Safeguarding adults training was an identified need for staff and arrangements had been put into place for staff to be able to access an online course. One GP took the lead with safeguarding children and for safeguarding adults at the practice. All of the GPs had been trained to level three for safeguarding children.

Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware of who the lead was for safeguarding children and who to speak to in the practice if they had a concern.

A proactive approach to anticipating and managing risks to patients was embedded and was recognised as the responsibility of all staff. There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments for example, children who were subject to child protection plans.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. Regular discussions took place with health visitors in regard to children and adults identified as at risk.

A notice was displayed in the waiting room, advising patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).

Requires improvement

Are services safe?

Medicines management

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

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Medicines requiring additional security were stored correctly according to guidance. GP home visit bags remained the responsibility of the individual GP.

The practice had a GP who was the prescribing lead and they were able to describe the processes in place for reviewing prescribing at the practice. This was supported by a pharmacist funded by the clinical commissioning group. We saw records which noted the actions taken in response to a review of prescribing data. For example, the practice pharmacist had undertaken a project to review high risk medicines such as anticoagulants.

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 patient group directives and evidence that nurses had received appropriate training to administer vaccines. There was a system in place for the management of medicines which required regular monitoring which followed the national guidance with appropriate action taken based on the results.

Blank prescription forms and Drug Misuse instalment prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely. There was a protocol for repeat prescribing which followed the national guidance and was implemented in practice. Repeat prescribing was overseen by the patient's GP so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any medicine changes.

Cleanliness and infection control

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

The practice had a nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Records indicated that staff received induction training about infection control specific to their role. We saw evidence the practice had accessed infection control audit documentation but no audits had been completed to provide an adequate review of infection control and preventing the risk of spread of infection within the practice. We found some areas in the practice where infection control measures had not been fully considered or implemented. For example, the routine cleaning of consulting/treatment room privacy curtains was undertaken by the GP or nurse who used the room and this was not recorded, so there was no assurance of the frequency of the process or that the curtains had been cleaned according to national guidance. We observed the waste bins in toilet areas did not have foot pedals; chairs used by staff and patients were fabric and were not able to easily clean; there was no established protocol for cleaning examination couches between patients; no protocol for sterilising peak flow meters, the baby changing area had no facility to clean the changing mat or dispose of soiled nappies.

We found the practice had adequate storage for personal protective equipment including disposable gloves, aprons and coverings. We also saw records were kept of staff immunisation status. Staff were able to describe the procedures they would follow to comply with the infection control guidance. For example, when carrying out intimate patient examinations or taking blood samples. There was also a policy for needle stick injury and staff we spoke with knew the procedure to follow in the event of an injury.

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

operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. Waste bins were foot operated in clinical area to maintain hygiene standards.

Staff were able to tell us about and show us the systems for safe disposal of clinical waste. The practice had a suitable contract with a clinical waste company. Clinical waste was stored in a lockable container at the rear of the premises however this area was not secured.

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). We saw the most recent assessment dated 2012 which identified the service as low risk with no additional control measures required.

Equipment

The practice was suitably designed and adequately equipped. The building, its fixtures and fittings were owned by the partners. There were no risk assessments of the building and premises and no maintenance programme. The practice manager employed specialist contractors as needed.

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 records such as certificates which confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The security alarm was also tested annually.

There was a range of seating available for patients, and chairs with arms to aid less mobile patients to stand; all appeared in safe condition. Adjustable examination couches were available in all treatment rooms which had appropriate privacy screening.

Staffing and recruitment

We were able to see 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 criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at six employee files and confirmed this had been implemented. When looking at the information within staff files we saw there was an induction checklist appropriate to the role of the staff member. Staff we spoke to confirmed these had been used.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice used known locum GPs to ensure consistency of care was maintained as far as possible. 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. This was reflected in the comments made by patients about the staff at the practice.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies and emergency equipment. We saw that any risks were discussed within meetings. There were systems in place for monitoring higher risk patients such as those with long term conditions, in receipt of end of life care and patients being treated for cancer. Welfare, clinical risks and the risks to patient's wellbeing were discussed weekly by the GPs and nursing staff. Patients who were identified as particularly vulnerable had a named GP and a care plan in place which specified potential problems and how the patient, in discussion with their GP, wished to be treated for them.

The practice also had a health and safety policy and a named responsible partner. We found health and safety at work information had been disseminated to each member of staff. Cleaning materials were stored in way which met the Control of Substances Hazardous to Health (CoSHH)

guidelines. The practice did not routinely undertake annual or monthly checks of the building or the environment. Action was taken when needed to rectify any issues as they occurred.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw there was first aid equipment available on site and trained nurses acted as first aiders for staff and patients. However there were no contingency plans in place to cover the times when no trained nurse was available to provide first aid.

We looked at the accident recording log book and found when accidents had occurred at the practice, they were recorded and appropriate action taken to prevent recurrence.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team if patients were vulnerable. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. All staff had completed basic life support training and knew where emergency medicines and equipment were stored and how to use it, for example, 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.

Emergency equipment available included oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children.

Urgent appointments were available each day both within the practice and for home visits. We were told that the practice prioritised requests for urgent appointments for children. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had never been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help if needed. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. For example, power failure, adverse weather, unplanned sickness and access to the building.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. We saw records that showed the system had been maintained and tested six monthly. There were no records of any equipment checks or fire system test in between these dates. The practice did not have a current fire safety risk assessment. Records showed that staff had completed initial fire training at induction. The practice had not undertaken recent fire safety training or practised 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 told us about their approaches to providing care, treatment and support to their patients. 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 found from our discussions that staff completed thorough assessments of patients' needs in line with NICE guidelines, which were reviewed when appropriate. New guidelines were disseminated to appropriate staff by the practice partners and the implications for the practice's performance and patients were discussed and required actions agreed.

Each GP had lead responsibility for specialist clinical areas .The practice nurses supported this work and held specialist training qualifications in order to hold nurse led clinics. Clinical protocols were in place and had been adapted by the practice to add value to patient care. The practice had a higher than England average number of patients with long term health conditions consistent with the demographic of the practice population. The practice had been effective by achieving above average Clinical Commissioning Group (CCG) results for management of long term conditions such as asthma, chronic obstructive pulmonary disease and diabetes.

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

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. We read information from Quality Outcomes Framework (QOF) 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 practice 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.

The team was making use of significant events, feedback from patients, clinical audit tools, clinical supervision and staff meetings to monitor the performance of the practice. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. The practice showed us the clinical audit which had been undertaken in respect of gynaecology referrals. The outcome of the audit was that more use could be made of the GP lead's specialist knowledge to facilitate patient treatment.

The practice also presented a variety of medicine audits which had been undertaken, all of which had clear actions taken which impacted on patient treatment. The local CCG regularly reviewed prescribing patterns to ensure patients were prescribed appropriate medicines.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice routinely shared information with the palliative care team and OOH service with a lead GP overseeing end of life care for the practice.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with varied interests such as dermatology and minor surgery. 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).

The practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. There was a GP clinical lead for the nursing team. For example, administration of vaccines, cervical cytology and family planning. Those with extended roles such as seeing 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.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwives and the community nursing team. 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 GP who saw these documents and results was responsible for the action required so patient care would be provided in a timely way such as directly contacting patients to advise them of any follow up care needed.

The practice worked jointly with other health and social care professionals and services to plan care for high risk patients through age, social circumstances and multiple healthcare needs to avoid any crisis in their health. The practice used computerised tools to identify patients with complex needs who then had multidisciplinary care plans documented in their case notes. Regular meetings with other professionals such as the community matron, community nursing teams, health visitors and palliative care team took place. Staff felt this system worked as there was a team approach to supporting their patients.

The practice took part in the unplanned admission avoidance enhanced service. Patients in this category who were recently discharged from hospital were reviewed within 72 hours. This was monitored by the staff on receipt of discharge summaries who ensured patients were followed up by the most appropriate staff member. All patients had a named GP.

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. The practice also used the electronic booking systems for secondary care appointments, patient to patient electronic transfer of medical records and summary care records.

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. The practice also had an internal system for shared documents and records which related to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, 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 in their practice. We were told patients were supported to make their own decisions and documented this in the medical notes. Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, with which they were involved. Care plans were reviewed three monthly or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those patients who lack capacity. 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. The practice confirmed that the GPs involved patients and families in 'Do Not Attempt Resuscitation' decisions.

Good

Are services effective?

(for example, treatment is effective)

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had 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 and written consent was documented in the electronic patient notes with a record of the discussion of relevant risks, benefits and complications of the procedure.

We spoke with and observed patients to confirm that consent was asked routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact and that if patient's declined this was listened to and respected.

Health promotion and prevention

The practice had met with the local authority and the Clinical Commissioning Group (CCG) in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness. We noted the culture of the practice was to use their contact with patients to help maintain or improve mental, physical health and well-being. This was reflected by the information available to patients in the waiting room.

The practice provided information and sign-posted patients to services which could help maintain or improve their mental, physical health and wellbeing. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. There were patient registers for patients assessed at risk such as those with learning difficulties, patients living with dementia and those with poor mental health. The practice manager told us the registers for patients were kept under review. For example, the practice kept a register of all patients with a serious mental illness and 83% had an agreed care plan, whilst 80% of patients living with dementia had also attended for an annual review. Similar mechanisms of identifying "at risk" groups were used for patients such as those receiving end of life care, and these patients were offered service support according to their needs.

The practice participated in the national screening programs such as those for cervical cancer, and bowel cancer. There was a process to follow up patients if they had not attended. The practice offered a full range of immunisations for children, travel vaccines and flu vaccines. We were told that flu vaccination clinics were held at weekends to encourage children and families to receive the vaccination. The most recent results indicated higher than CCG average number of patients receiving childhood immunisations for the time period 1 April 2013 – 31 March 2014.

There was a policy to offer letter and telephone reminders for patients who did not attend for screening such as cervical smears; the practice audited patients who did not attend.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice.

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 latest national GP patient survey information was a survey of 313 patients with a return rate of 41%. The evidence from all this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed 90% of patients felt that their overall experience was good or very good in comparison to the CCG average of 86% and England average of 85%.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 26 completed cards which 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. Patients stated they felt GPs took an interest in them as a person and the overall impression was one of wanting to help patients. All the patients we spoke with said they would recommend the practice, as evidenced from the responses to the friends and family survey.

Patients also spoke highly of the relationships between them and the staff at the practice. We heard staff recognised and respected patients' needs taking personal and social needs into account. For example, the practice worked in partnership with numerous organisations to provide shared care for patients such as having a substance misuse worker based at the practice.

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

We observed that receptionist answered calls to the practice when dealing with patients at reception. This was also commented on by a patient who spoke with us. The design of the building did not allow for a separate area away from the reception desk for calls to be taken where they could not be overheard. This was raised with the practice manager to review their protocols for receptionists taking calls whilst dealing with patients at the reception desk. The practice also had a private room off the waiting room if patients needed privacy for discussions or a completely private area in which to wait for their appointment.

Care planning and involvement in decisions about care and treatment

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

- 98% of respondents had confidence and trust in the last GP they saw or spoke to with the CCG average at 96% and England average 95%.
- 92% would recommend the practice to other patients with the CCG average at 70% and England average 78%.

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 telephone translation services were available for patients who did not have English as a first language.

We found that 2.8% of the patient population identified as vulnerable had their own care plan. We were told that the GPs acted as the care coordinator for a number of patients, all the plans had been reviewed. We found this provided a continuity of care and support for the patient. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the

Good

Are services caring?

practice and rated it well in this area. For example, 97% said the last GP they saw or spoke with was good at treating them with care and concern above the CCG average of 85% and England average of 85%. The views of the patients we spoke with on the day of our inspection and the comment cards we received were consistent with this patient response. For example, these highlighted that staff responded compassionately towards carers and family members when they needed help and provided support when required.

Notices in the patient waiting room, on the patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We were told how access to appointments was flexible to patients who were carers. We were told how the GPs and health care staff were flexible in providing home visits to reduce the difficulties carers of patients had attending the practice. An example of this being home visits to patients and their carer for influenza immunisations.

One of the staff acted as a carer's champion for the practice; the computer system alerted GPs if a patient was also a carer. The practice encouraged patients who were carers to be identified so relevant information could be sent. This may include benefits advice, carer breaks/ holiday, emergency card scheme, introduction to voluntary agencies and social services, as well as general support.

Staff told us that if families had suffered bereavement, their usual GP contacted them. Bereaved patients usually are visited at home and are then followed up 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.

The information from patients showed patients were positive about the emotional support provided by the practice staff. Some of the GPs also continued to make themselves available in the out of hours periods for palliative care patients so they had continuity of care. The practice had also been proactive in identification of social isolation amongst patients and had worked to ensure there was access to facilities such as a volunteer driver service. They also maintained a local news information board in the reception area to keep patients informed about local events.

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. 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.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. Patients could also speak to the duty GP by telephone if they were anxious. The practice had provided a responsive service by holding clinics, such as the diabetes clinic, on a regular day each week for patients who found it difficult to attend variable appointment times. A GP with specialist interest supported patients by reducing the need to attend hospital for minor operations and joint injections as required. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as talking therapies, and the 'Off The Record' service for young patients experience mental health difficulties. The practice could access a pathway navigator and specialist nurse for patients living with dementia. The practice offered 'familiarisation sessions' for patients with learning disabilities to enable them to be confident to attend the practice for appointments. We saw accessible documents were used by the practice to enable patients with learning disabilities to be informed about the practice and examinations.

There was a computerised system for obtaining repeat prescriptions and patients used both the electronic request service, posted or placed their request in a drop box in reception, patients told us these systems worked well for them. The practice planned to use electronic prescribing and had arranged with local pharmacies that urgent prescriptions were delivered to older or infirm patients on the same day.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice provided access to elearning about equality and diversity training for all staff.

The premises and services had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrances to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in residential or nursing homes.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

The practice is open on Monday to Friday 8am – 6.30pm for on the day urgent and pre-booked routine GP and nurse appointments. The practice had a ratio of 30/70 on the day and pre-bookable appointments which was kept under review to ensure demand was met.

The practice offered unlimited access to GPs for telephone consultations; appointment need was audited and usage predicted which allowed for adjustment in the number of pre-bookable appointments available. Appointments were not limited by 10 minute slots and were able to use their clinical judgements to book appropriate length of appointments for patients.

The practice did not provide Out of Hour's services to its patients, this was provided by BrisDoc and information on the-Out-of-Hours service was provided to patients. Appointments were available outside of school hours for children and young people. The practice worked to provide inclusive services for younger patients, such as having the public health chlamydia screening service based at the practice and operating the 4YP initiative which enabled young people to easily access a GP consultation. Comprehensive information was available to patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Patients told us they were aware that appointment times were based on 10 minute slots but lasted for however long was needed. This system was valued by patients although it meant that they may have had to wait beyond the time they expected. Patients were made aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The feedback we received from patients was that they were very happy with their access to appointments. The practice also had an online booking system for planned appointments.

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. This also included appointments with a named GP or nurse. The patient record system had an alert to highlight patients who required longer appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Information was on display in the patient areas and included on the practice website. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. None of the patients we spoke with had ever needed to make a complaint about the practice but told us they felt the practice would listen and respond to their concerns.

We looked at three of the 12 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The complaints ranged from a variety of issues, such as staff attitude and delayed referral to other healthcare providers. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team. We saw that from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future.

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 was in the process of transformation with significant changes in the leadership of the practice and introduction of new ways of working. However there was a clear vision to deliver high quality care and promote good outcomes for patients. The practice had planned a whole service away day to promote understanding and ownership of the new vision and values. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. The practice did not run personal lists but every patient had a named GP. Patients could exercise choice in which GP they saw. Staff told us they treated patients with courtesy, dignity and respect at all times and this was confirmed by patient feedback. The practice also participated and engaged with four other practices in North Bristol on a cluster basis to work cooperatively to benefit patients in the practices.

Governance arrangements

The practice employed a practice manager for the management of the business and administration of the service. Their responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of policies which had been reviewed, for example the recruitment policy and induction programmes, which were in place to support staff. We were shown the online information that was available to all staff. Those we spoke with knew where to find these policies if required.

GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals. Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. The practice also had a policy to follow for patients who made freedom of information requests.

We spoke with ten members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice was equitable with national standards and was above average for the local Clinical Commissioning Group (CCG) and England average in a number of clinical indicators. The practice periodically looked at these alongside other indicators such as survey results to provide an in depth review of service provision. The practice had undertaken clinical and medicines audits which it used to monitor quality and systems to identify where action should be taken.

The practice held weekly partners meetings to discuss quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. We observed a clinical governance meeting which was held at the practice which contained elements of discussion, evaluation and learning. We were told the content of the meeting varied and guest speakers were invited such as a patient in recovery from substance misuse who spoke to practice staff about their experiences. They also used a programme of regular multidisciplinary meeting with other healthcare professionals to identify risks to patients so they were identified and mitigated before they became issues.

Leadership, openness and transparency

There was a leadership structure with named members of staff in lead roles, each partner GP in the practice led on a specific area. There was an established agenda of meetings for business and clinical development. We reviewed the minutes and found generally they were very brief and lacked detail. Where actions had been identified there was not always a responsible person identified to complete the action or a timescale. The risk of this was action was not taken in a timely way and could impact adversely on the practice. This was raised with the practice manager for action. The practice had a routine 'huddle meeting' each morning to share any news or events which may impact on the daily work.

We saw arrangements between GPs to cover the clinical work were clearly documented and provided a safety network for patients. For example, when a GP was absent, the duty GP would check correspondence and results, so that nothing urgent was missed, and nothing was filed until it was reviewed by the GP who requested the test.

Are services well-led?

Good

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

Staff were able to tell us what was expected of them in their role and how they kept up to date. Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team. We heard from staff at all levels that team meetings were held regularly and the practice had planned a yearly meeting for September 2015 to give staff the opportunity to contribute the practice developmental proposals and vision.

A GP partner held lead responsibility within the practice as the Caldicott Guardian and was clear about their role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place for confidentiality, data protection and information sharing.

Seeking and acting on feedback from patients, public and staff

The practice demonstrated a commitment to seeking and listening to patient views. They showed us a range of evidence, such as patient feedback, compliments and complaints they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement. For example, the practice had gathered feedback from patients through the friends and family questionnaire which had elicited a 100% response for recommending the practice. There was also an ongoing practice survey titled 'How did we do today?' available in the waiting room for patients to complete.

The practice had gathered feedback from staff through team 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.

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

Management lead through learning and improvement

We found the practice were in the process of reviewing how they worked and had employed a consultant practice manager to review and report on the day to day work of the practice. For example, by the consultant practice manager's report found the systems for auditing and reviewing work systems and premises were not robust enough to demonstrate a programme of quality improvement. The review had identified areas for development which the practice was beginning to address such as having sufficient administrative staff.

The practice was proactive in planning for future needs and had recognised several areas for development. An example of this was the plan to initiate 'virtual wards' for all vulnerable patients so that patients could be more closely monitored and supported. The practice was also in the process of applying for an improvement grant to develop the premises.

GPs and nurses were provided with opportunities for additional training to develop new services and enhance their skills. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Bristol Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. In the staff files we looked at we saw that regular appraisals took place which included a personal development plan. However we found that records of training were kept inconsistently whereby some staff maintained their own records whilst others were kept on HR files. This was raised with the practice manager as there was no oversight of training.

Learning also came from significant events, clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date. The practice had completed reviews of significant events, complaints and other incidents. Significant events were a standing item on the practice meeting agenda and were attended by the GPs and the practice manager. There was evidence the practice had learned from these events and that the findings were shared.

Are services well-led?

Good

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

The practice was a GP training practice with one partner who took the lead for GP training.The ethos of the practice was that GPs in training brought new ideas and ways of working to the practice, and were able to challenge established practice.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not have infection control risk assessments and must comply with the guidance from the Department of Health about the prevention and control of infections and undertake risk assessments for the prevention and control of infection. **Premises and equipment 15** (2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust system in place to assess, monitor and improve the quality and safety of the service and must establish and operate systems which identify and mitigate any risks to patients. **Good governance 17** (2) (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity