Dr DS Walsh and Partners

Quality Report

Dr DS Walsh and Partners
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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

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Overall summary

Letter from the Chief Inspector of General Practice

Dr DS Walsh and Partners is situated in the inner city area of Bristol with approximately 9797 registered patients. We undertook a comprehensive announced inspection on 2 December 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector, a practice nurse specialist advisor and GP specialist advisor.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Bristol Clinical Commissioning Group (CCG), NHS England and Healthwatch.

Our key findings were as follows:

- Patients were able to get an appointment when they needed it.
- Staff were caring and treated patients with kindness and respect.
- Staff explained and involved patients in treatment decisions
- Patients were cared for in an environment which was clean and reflected good infection control practices.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice had systems to identify, monitor and evaluate risks to patients.
- Patients were treated by suitably qualified staff.
- GPs and nursing staff followed national guidance in the care and treatment they provided.

We saw an area of outstanding practice:

- The practice worked in partnership with a substance misuse and alcohol rehabilitation project to offer a shared care treatment service to a considerable number of patients. This joint working led to other

Summary of findings

treatment being made accessible, for example, a nurse led drop in clinics enabled patients who were intravenous drug users to access treatment for wounds.

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

Importantly, the provider must:

- Ensure there are systematic processes in place for the safe management of medicines

In addition the provider should:

- Ensure that staff understand and implement the practice's agreed protocols and procedures for dealing with incidents and emergencies
- The practice should have a patient participation group.

Professor Steve Field CBE FRCP FFPH FRCGP

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 must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses but systems, processes and practices are not always reliable or appropriate to keep patients safe. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Monitoring whether safety systems are implemented was not robust. For example, the medicine management systems did not include a check of GP bags where we found out of date medicine.

Are services effective?

Good

The practice is rated as good for providing effective services. Data provided by NHS England showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) 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 planned. The practice had an appraisal system and staff had personal development plans. Staff worked closely with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Translation services were available to support patients all of the time the practice was open. We also observed that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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. The practice had accessible facilities and

Summary of findings

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

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. 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, 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.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. 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. For example, telehealth enabled individuals to take more control over their own health, by allowing them to monitoring vital signs, such as blood pressure, and transmitting the information to a monitoring centre.

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. 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. The practice had developed specific services for female patients with female genital mutilation and promoted the '4YP' (for young people) health promotion programme for patients.

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

Summary of findings

working age population and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice worked in partnership with a local drug project to provide shared care for patients who misused substances. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

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 and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. For example, the practice registered patients who were homeless. It signposted vulnerable patients to 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 patients with dementia). Patients experiencing poor mental health were offered 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 including MIND and SANE. 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.

Summary of findings

What people who use the service say

We spoke with six patients visiting the practice and we received 29 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 and the last Care Quality Commission inspection report about the practice.

The majority of comments made or written by patients were very positive and praised the care and treatment they received. For example, patients had commented about seeing their preferred GP at most visits and about being involved in the care and treatment provided.

We were told that patients generally found access to appointments a challenge because they could not get through by telephone. We observed and were told that patients turned up at the practice to book an appointment. This could be later in the day so patients went away and returned later at their appointment time. However, we were also told by all of the patients that they knew if they asked for an appointment they would be seen on the same day. The most recent GP survey showed 56% of patients found it easy to get through to the practice by telephone, this was below the CCG average. Patients also told us about using the practice's online booking systems to get appointments.

Patients told us their privacy and dignity was respected during consultations. The GP 2013 survey showed 92% of patients said the last GP they saw or spoke with was good at explaining treatment, which was above CCG average. The practice had also commenced their current 'friends and family' survey.

Areas for improvement

Action the service MUST take to improve

- Ensure there are systematic processes in place for the safe management of medicines.

Action the service SHOULD take to improve

- Ensure that staff understand and implement the practice's agreed protocols and procedures for dealing with incidents and emergencies
- The practice should have a patient participation group.

Outstanding practice

The practice worked in partnership with a substance misuse and alcohol rehabilitation project to offer a shared care treatment service to a considerable number of patients. This joint working led to other treatment being made accessible, for example, a nurse led drop in clinics enabled patients who were intravenous drug users to access treatment for wounds.

Dr DS Walsh and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr DS Walsh and Partners

Dr DS Walsh and Partners is situated in the inner city area of Bristol. It has approximately 9797 patients registered with a range of cultures and ethnicity with a high number of patients from the Somali community (approx. 40% of registered patients). There is an interpreter available onsite who will assist with any translation issues.

The breakdown of patients age at the practice is:

0-4 years old: 9.21%

5-14 years old: 11.25%

15-44 years old: 47.26%

45-64 years old: 19.3%

65-74 years old: 6.29%

75-84 years old: 4.56%

85+ years old: 2.13%

The practice is in an area of high deprivation with child deprivation index of 53% over twice the national average, with a high level of child emergency admissions in the asthma, diabetes and epilepsy categories. The patient demographic shows high number of younger adults on the patient list with high levels of unemployment and poverty.

Living in relative poverty means that families tend to make lifestyle choices that are less healthy than those made by more affluent families. The health centre hosts a variety of additional services planned to meet the specific health issues of the patient group such as those related to smoking, diabetes, obesity, and chronic obstructive pulmonary disease. For example there is a tuberculosis support team based onsite and a Community Lung Education and Rehabilitation team (CLEAR) for pulmonary rehabilitation. The practice holds a clinic to support patients with female genital mutilation which is overseen by one of the practice GPs.

The practice operates from one location:

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The practice is made up of five GP partners and two salaried GP's of both genders working alongside a nurse practitioner, seven qualified nurses and three health care assistants (all female).

The practice was previously inspected by the Care Quality Commission (CQC) on 12 November 2013 and was found to be compliant in the five outcome areas that were inspected.

The practice has a general medical services contract with some additional enhanced services such as extended hours for pre booked appointments. The health centre was open 8am – 6.30pm with appointments available between 8.30am -12.30pm and 2pm – 5.30pm. Pre booked appointments (enhanced services) 6.30 and 7.30 pm on Tuesday and Thursday evenings, 6.30 and 7.00pm on Tuesday and Wednesday evenings and on alternate Saturday mornings from 8.00 to 10.00am.

Detailed findings

The practice does not provide out of hours services to its patients, this is provided by BrisDoc.

The CQC intelligent monitoring placed the practice in band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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 we had received from the provider and asked other organisations to share their information about the service.

We carried out an announced visit on 2 December 2014 between 8am - 5pm.

During our visit we spoke with a range of staff, including GPs, nurses, practice manager and administrative staff. We also spoke with healthcare professionals based at the health centre from the midwifery service and the community matron, and the link worker who provided translation services for patients.

We also spoke with patients who used the service. We observed how patients were being cared for and reviewed the patient information database to see how information was used and stored by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older patients (over 75s)
- Patients with long term conditions
- Mothers, children and young patients
- Working age population and those recently retired
- Patients in vulnerable circumstances who may have poor access to primary care
- Patients experiencing poor mental health.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they reported incidents and used national patient safety alerts to review and change practice. 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 were shown a report of an incident of theft and advisory action given to staff to avoid any reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred during the last year, and we were able to review these with individual GPs. Significant events were a standing item on the practice meeting agenda and we read in the minutes that actions from past significant events and complaints were reviewed. There was evidence the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to relevant 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 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 all staff had received relevant role specific training on safeguarding. 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, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role for example GPs were trained to level 3 in child protection. All staff we spoke to were aware who the lead staff were and who to speak to in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was on the waiting room noticeboard and in consulting rooms. Nursing staff were available to act as a chaperone, and had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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 appropriate liaison with partner agencies such as the police and social services. The practice held monthly priority family review meetings with health visitors and midwives, where any risk were discussed and action agreed.

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw the practice staff followed the policy and recorded when there was any deviation in temperature range. However, they did not

record when the the refrigerators had had returned to within the acceptable temperature range. This meant that the provider could not be assured that medicines were stored within the recommended temperature range.

We asked the lead nurse about the process in place to check medicines kept by the practice were within their expiry date and suitable for use. We were told that medicines were checked regularly and there was a record of the completed checks. The record of stock checks for these medicines showed that the process was not completed regularly. For example, we read that the last recorded date of the stock check for one medicine was 1/9/14 whilst the last recorded date for the stock check for another medicine was 13/01/14. We carried out a spot check and found the majority of the medicines we checked were within their expiry dates. However we found these two medicines which were out of date. The provider acknowledged the medicines were out of date and removed them from use.

We asked the GPs about the medicines they took on home visits. We looked at the medicines which two GPs were currently taking out on visits. We found that one medicine was out of date and the calibration test for a spirometer used on visits was not up to date. We asked about the procedures in place to check these medicines and medical equipment. We were given a copy of the Standard Operating Procedures for the safe handling of Controlled Drugs (CDs) by Healthcare Professionals employed by Bristol CCG in the community and GP Surgeries. The practice manager confirmed to us this was followed and there was no practice specific policy in place.

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

The practice employed a community pharmacist one day a week. This facilitated monitoring of medicine management in respect of prescribing and guided GPs to implement best practice. There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely. Repeat prescriptions were managed according to local guidance; patients on short term medicines did not receive repeat prescriptions.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The community pharmacist undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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 member of staff 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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, 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. Staff were able to describe how they would use these to comply with the practice's infection control policy. There

was also a policy for needle stick injury. We were told the process which had been followed when an incident occurred. We were told by the staff they had not followed their own procedures. We raised our concerns this had put a member of staff at risk with the practice manager who stated they would take immediate action to investigate the incident.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure monitors. However we found one spirometer which had not been included.

Staffing and recruitment

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 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.

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 enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff 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 were in line with 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 annual and monthly checks of the building, the environment, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to read.

We found the building was regularly audited and any identified risks were noted and action taken to mitigate the risk. We saw that any issues were raised and discussed at GP partners' meetings and within team meetings.

Population group evidence

- There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.
- Emergency processes were in place for acute pregnancy complications.
- Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.
- The practice monitored repeat prescribing for people receiving medication for mental ill-health.

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 (a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular

tachycardia in a patient and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm.) When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and had agreed a protocol for dealing with emergencies. However we asked two staff about this, they were unclear about the protocol and who should take the lead for dealing with emergencies.

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

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

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that not all staff were up to date with fire training. The practice manager told us they had fire training planned to address this issue.

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. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

National data showed that the practice was lower than the clinical commissioning group (CCG) average for referral rates to secondary care services but had a higher than clinical commissioning group average of 'did not attend' rate for outpatient appointments. The practice manager told us they were aware of this and patients coming back to the practice with the same complaint impacted on GP time. However, we were told patients preferred to visit the practice where they were comfortable and could access the services of a familiar translator to facilitate the consultation. Additional appointment time was allowed with the GP and translator to enable patients to understand their treatment options.

The GPs told us they lead within the practice 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 in their specialist areas. For example, a GP who lead on asthma told us this accessibility supported staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts, and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to report performance and highlight areas for improvement.

The practice showed us six clinical audits that had been undertaken in the last two years. We saw these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, for example, the practice participated in an audit of end of life care. Specifically the audit looked at the palliative care list size in detail. We saw different disease groups and if a do not attempt resuscitation (DNAR) had been recorded. We read how many patients were on Adastra (electronic record accessible for out of hours and emergency care), and was there an advanced care plan (ACP) in place with preferred and actual place of death recorded. We saw, for example, the number of patients on the palliative care list for the practice had reduced after the audit. Other examples included audits to confirm that the GPs who undertook fitting of intrauterine devices were doing so in line with their registration and NICE guidance.

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 the outcomes framework (QOF). The QOF is a national performance measurement tool. For example, we saw an audit regarding use of D-dimer (a small protein fragment present in the blood after a blood clot is degraded by fibrinolysis. It is so named because it contains two cross-linked D fragments of the fibrin protein) tests in the treatment to deep vein thrombosis. Following the audit, there were recommendations made for near patient testing (onsite testing) and how GPs calculated and recorded Wells scores (a system for calculating the probability of risk of a deep vein thrombosis) both of which had implications for rapidity of treatment for patients.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, we found the percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test had been performed in

Good

Are services effective?

(for example, treatment is effective)

the preceding 5 years was worse than average. We were told that the practice had used the link worker translators to directly contact patients who had failed to attend for screening, to offer explanation and reassurance to patients about the process.

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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff in conjunction with the clinical pharmacist, regularly checked that 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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. If they continued to prescribe it the reason why they decided this was necessary was recorded on the patient record. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support which was revisited yearly. We saw that the practice had initiated this training using the equipment they had on site to make it more applicable and familiarise themselves with their own resources. We noted a good skill mix among the doctors with six having additional training in areas such as children's health. 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

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. 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 were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, for the administration of vaccines, cervical cytology and pulmonary disease. Those with extended roles for example, patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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 communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example, a weekly meeting for children and families in vulnerable circumstances. These meetings were attended by district nurses, social workers, palliative care nurses and decisions

Good

Are services effective?

(for example, treatment is effective)

about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We heard how the practice worked with voluntary organisations for shared care for patients with drug and alcohol dependency this included those with no fixed abode. The practice had approximately 160 patients in the shared care treatment programme. In addition we found the nurses operated a drop in clinic for patients who were intravenous drug users who may require wound dressings.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice had also 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).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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 in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff for example, with making do not attempt resuscitation orders. This 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. 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the clinical commissioning group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity such as the incidence of tuberculosis (TB) which was recorded as 19.6 per 100,000 population (2010-12) which is significantly worse than national average figures. This was linked to changes in the Bristol population demographics due to a higher number of patients moving into the area from countries where TB is more prevalent.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in during routine appointments. We identified a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18-25, offering smoking cessation advice to smokers and by encouraging patients to self-refer to services such as talking therapies to support their emotional wellbeing.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75. GPs told us they offered these checks when patients in this age range came in for routine appointments. A GP showed us how patients were followed up the same day if they had risk factors for disease identified at the health check and how they scheduled further investigations or consultant appointments.

The practice had a range of ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. These groups were offered further support according to their needs.

The practice's performance for cervical smear uptake was worse than the national average but in line with other local practices. There was a process to offer telephone reminders for patients who did not attend for cervical smears with a named nurse. The named nurse was responsible for following up patients who did not attend 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 for all immunisations was in line with other practices in the CCG area. There was a clear process for following up non-attendance for immunisations by the named practice nurse.

The practice kept a register of patients who were identified as being at high risk of hospital admission, had a diagnosis of dementia, or who were nearing the end of their life. Up to date care plans were completed and shared with other providers such as the out of hours service. Multidisciplinary case management meetings took place and care plans were updated. All patients over the age of 75 had a named GP and for those who lived in a residential or nursing home there was one named GPs who made regular visits.

The practice had system alerts for particular needs such as older patients who had difficulties with mobility, vision and hearing. Flexible appointment times including 20 minute appointments were available to older patients and other vulnerable groups if required. Some patients with particular needs for example, those with who needed the services of a translator, automatically defaulted to 20 minute appointments and an alert was added if patients needed to be seen by a specific GP.

Older patients with more complex needs and who were at risk of unplanned hospital admissions had care plans in place. These were reviewed at regular multi-disciplinary team meetings. Unplanned admissions were monitored and discussed. A named member of staff contacted all these patients after discharge from hospital and alerted GPs of any concerns. Read codes were on the patient record to indicate if they had carers.

Patients with long term conditions such as diabetes, heart failure or multiple conditions received regular and annual reviews. Patients with diagnosed diabetes received regular monitoring and had access to an annual foot check and could be referred to a local chiropody service. Basic eye testing was provided in the practice with patients being referred to other services for more detailed checks. When health promotion and lifestyle advice was offered to patients this was recorded in the patients notes. Some housebound patients used telehealth systems to support them to manage their long term condition. Patients with long term conditions were signposted to appropriate patient groups and support networks such as Asthma UK.

All patients with long term conditions had a named accountable GP. Care was tailored to individual needs and circumstances with regular reviews if necessary prompted from repeat prescribing system and formal recalls. This included patients who required international normalized ratio (INR) blood tests and high risk drug monitoring. Disease management clinics were run by multi-skilled nurses and included, diabetes, asthma and chronic obstructive pulmonary disease (COPD). The practice operated a formal appointment recall system for patients in these groups. Home diabetic checks and flu vaccinations were provided for housebound patients. Flexible access to services including same day appointments, same day telephone consultations and flexible disease management clinics were also available.

All patients have a named GP and all families were registered with same GP to assist with continuity of care. Families, children and young people were supported by a range of practice services. Immunisation rates for all standard immunisations were either in line with, or better than the local area average with 100% completion for some

Good

Are services effective?

(for example, treatment is effective)

illnesses for example, combined infant vaccinations. Regular multi-disciplinary team meetings took place with health visitors to discuss children with protection plans and known to be at risk. GPs and nurses provided support for families at a local family assessment centre. Child protection training was provided for all staff. A midwife and health visitors worked from the practice which aided close joint working.

Young people were offered appointments with a female or male GP if requested They were provided with contraception advice, sexual health advice and contraception medicines. We saw information was available which sign posted young people towards sexual health clinics and posters offered more information about extra services such as contraception advice. Chlamydia testing packs were available in the practice. Same day appointments were provided for discussions about emergency contraception. School leaver immunisation sessions targeted contraception health promotion. The practice implemented the 4YP programme which promoted health checks for young people by inviting each patient by letter to visit the practice for a health check when they reach 16. Children and young people were treated in an age appropriate way and were recognised as an individual with their preferences considered.

Working age patients had access to a range of appointments outside of normal practice times. These appointments included late evening and weekend appointments. These could be booked via an online facility or by telephone. Flexible appointment times including same day telephone consultations were available to working age patients. Opportunistic health checks were offered when these patients attended routine appointments as were cervical smears and blood pressure checks. The practice provided a range of lifestyle information for this group of patients including how to get support for managing stress at work, depression and other mental health problems.

A range of additional in-house services including, phlebotomy with centrifugation (a process of separating samples for later processing) of samples when needed, electrocardiograms (ECGs), spirometry (a test that can help diagnose various lung conditions), ambulatory blood pressure monitoring (a non-invasive method of obtaining blood pressure readings over a 24-hour period), blood tests monitoring and NHS health checks.

On-line prescribing and appointments had been introduced and the practice was currently working towards e-prescribing. Patients were also provided with information about various local support groups and voluntary organisations such as those who provided community therapy services and speech and language therapy.

The practice operated a 'no barriers' policy for patients who wished to access a GP and included immediate necessary registration when appropriate, this included patients with no fixed abode. These patients were encouraged to participate in health promotion activities such as breast screening, cytology and in-house smoking cessation clinics. We found the nurses operated a drop in clinic for patients who were intravenous substance misuse users who may require wound dressings. The practice also offered shared care for patients with substance misuse and alcohol dependency. Patients were able to access the practice services without fear of stigma or prejudice and a translation service was available.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Services (CAMHS) and Adult mental health services. A named accountable GP was available to patients who experienced poor mental health with flexible appointment times including same day emergency appointments and telephone consultations. Staff were trained to be sensitive to patients distress and to offered extended appointment times when appropriate. GPs were informed immediately of any undue distress being shown by patients. The GPs told us the practice had good working relations with an accessible local Crisis Team and could book same day assessments for patients in need of prompt interventions. Records showed there were annual reviews for patients on the mental health register. The annual review included help and support for carers. The practice used review appointments to encourage health promotion.

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. 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 73.9% in the middle range for patients who would recommend the practice and 97% of respondents said the last GP they saw or spoke with was good at listening to them. information on NHS Choices showed the practice as having three stars for dignity and respect and 97% of respondents had confidence and trust in the last GP they saw or spoke to. 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. 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A system had been introduced to allow only one patient at a time to approach the reception desk. Staff told us that if they had any concerns or observed any instances of discriminatory or if patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was a 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 were shown an example of a report on a recent incident that showed the actions taken had been robust.

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 84% of practice respondents said the GP involved them in care decisions and 92% of respondents said the last GP they saw or spoke with was good at explaining tests and treatments. Both these results were above average compared to clinical commissioning group (CCG) area and reflected the individual comments from patients during the inspection. 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 corroborated these views.

Access to the service

The health centre was open 8am – 6.30pm with appointments available between 8.30am -12.30pm and 2pm – 5.30pm. Pre booked appointments (enhanced services) 6.30 and 7.30 pm on Tuesday and Thursday evenings, 6.30 and 7.00pm on Tuesday and Wednesday evenings and on alternate Saturday mornings from 8.00 to 10.00am.

The policy of the practice was that if a patient had an urgent medical problem they would always be given an appointment to see the GP that day even if all the appointments are filled. This was confirmed during the conversations we had with patients. They told us they were never turned away. Patients could request to see a certain GP but may have had to wait longer for an appointment. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Good

Are services caring?

how to book appointments through the website. There were also arrangements which ensured 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 about the out-of-hours service was provided to patients. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patients told us about how difficult it was to get through to the practice by telephone to book an appointment. The patient survey results showed only 56% found it easy to get through to the surgery by phone. Some patients had commented about the time to wait to get through and the cost to them, whilst others raised the issue of English not being their first language and the difficulty understanding the telephone system. Because of these issues patients went to the surgery to book an appointment directly at the reception desk. We observed this in practice when we inspected. Consequently some patients arrived at the practice when it opened and had to return later in the day for their appointment. Patient also told us they often needed to wait after their designated appointment time which could be difficult if they had other commitments. The patient survey indicated that 53% of respondents usually waited 15 minutes or less after their appointment time to be seen, however they had an expectation that during their appointment they would be given the time necessary to address their problem. Both of the survey results were below the average for the clinical commissioning group area.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and 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. For example, patients at the practice could access psychological support services either through self referral or by referral from a health care professional.

Staff told us that if families had experienced a bereavement, patients usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 people'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 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, the practice had found for a minority of female patients there was a need for expertise in female genital mutilation. One GP had developed special interest in this field and had worked with local commissioning teams to enable a specialist clinic to be funded to support patients with this condition.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. One member of staff told us that an interpreter or telephone interpretation service was used for consultations where English language was not understood. We were told some 46 language translations were available. Staff had a good cultural awareness that it would not always be appropriate for a relative to interpret on behalf of someone else. An example we were given was that of a son or brother, interpreting on behalf of a female patient with sensitive health issues. One patient of Somalian descent told us that it was important that his wife could access a female GP. We also spoke with a link worker who worked at the practice. This person was employed by a community health group but worked in the practice and other practices in the local area. We were told their role was to provide an advocacy and interpretation service for those people whose first language was not English. We were told this ensured non English speaking patients were given support to make informed decisions about their care and treatment. The link worker told us how they reached out to the diverse population of the local area to empower and educate patients who may otherwise be reluctant to seek medical advice. For example, we were told that they were involved in talking to a female patient about the importance of cervical screening and were able to agree a mutually acceptable time for patients to come into the practice and be supported by them. The link worker emphasised the value of on the day appointment to the patients who found telephone communications a challenge.

The practice provided equality and diversity training and staff we spoke with confirmed that they had completed the equality and diversity training.

The premises were purpose built and were accessible to patients with disabilities as consultation and treatment rooms were on the ground floor. One area of the reception desk was lower making it more accessible for wheelchair users. They had accessible toilets including baby changing facilities, and a loop system for patient with hearing impairments. We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. We observed the waiting room also had a range of seating to meet patient requirements. The patient car park had designated bays for patients with disabilities close to the entrance and patients who needed to access the first floor could do so via a lift.

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 was in place such as posters displayed and a summary leaflet available. 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.

The practice had a low number of complaints. We spoke with staff about complaints and they were able to demonstrate that they had acted responsibility and demonstrated learning from these issues. We found that additional training and learning from complaints had been included as part of continuing professional development.

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 work as an integrated primary care team to deliver high quality seamless care across the provider organisations working at the health centre, and promote positive outcomes for patients. We spoke with a range of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

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 of any computer within the practice. We looked at five of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All the 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 the senior partner was the lead for older people. We spoke with a range 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 practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we read an audit of patient waiting room times for their appointment. This was undertaken to improve patient satisfaction with waiting time which was below the national benchmark average. The audit concluded that reorganising the scheduling of appointments had reduced waiting times for patients.

The practice held weekly clinical meetings to discuss performance and any risk such as child protection issues, and six weekly partners meeting. We looked at minutes from the partners meetings and found that performance, quality and future planning had been discussed.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice manager was responsible for human resource policies and procedures. We saw a number of policies, for example a training policy was in place to support staff. Staff could access through the practice intranet, various policies which included those on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the annual NHS patient surveys and had commenced their families and friends survey. We looked at the results of the annual patient survey and 56% of respondents found it easy to get through to this surgery by phone which was below the CCG average of 71%. The practice manager told us this had been identified across the CCG area as an issue and an integrated telephone system had been discussed to resolve the issue.

At our last inspection we found the practice did not currently have a patient participation group. The practice manager informed us they had placed information in the waiting area to encourage people to take part. However the practice had not been successful in this and there was no patient participation group.

The practice had 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.

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five 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 staff training sessions where guest speakers and trainers attended.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People who use services were not protected against the risks associated with unsafe use and management of medicines because the arrangements for the recording and monitoring of medicines were ineffectual.**