Heathfield 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 Heathfield Surgery on 3 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe services. It was also good for providing services for people with long-term conditions, families, children and young people, older people and people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia) and for working age people (including those recently retired and students).

The Heathfield Surgery provides services to people living in the Wealden area. At the time of our inspection there were approximately 12,260 patients registered at the practice with a team of seven GP partners. The practice was also supported by a salaried GP, nurses, healthcare assistants and a team of reception and administrative staff. Heathfield Surgery is able to dispense medicines to its patients and is a GP training practice. At the time of the inspection the practice was providing training and support to one registrar.

We visited the practice location at The Heathfield Surgery, 96-98 High Street, Heathfield, East Sussex,

TN21 8JD. Heathfield Surgery also operates a branch surgery at The Firs Surgery, Little London Road, Cross in Hand, TN21 0LT. We did not visit the branch surgery as part of our inspection.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

Summary of findings

- 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 and urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice and PPG had produced a comprehensive Young People's Health Guide.

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

Importantly, the provider must:

- Review how patients are informed regarding medicine dose changes following blood test results and to follow national guidance.
- Review the management of the repeat prescribing system to ensure all staff are aware of the practice policy not to issue repeat prescriptions over the telephone.

In addition the provider should:

- Ensure that training records are updated when staff have completed training.
- Ensure that there is a full practice meeting which includes all members of staff

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained. However, we noted that the practice was not following national guidance in relation to informing patients about changes required to their medicine dosage following a blood test for a particular medicine. The practice had risk assessed those staff who needed to have a criminal records check however, there was no written risk assessment for us to review.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental 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 was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care.

Are services caring?

Good

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

Summary of findings

saw that staff treated patients with kindness and respect, and maintained confidentiality. During the inspection we witnessed caring and compassionate interactions between staff and patients. Patients had access to local groups for additional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. During the inspection we observed that two patients were given appointments within 20 minutes of attending the practice for an appointment. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities. The layout of the building enabled patients with mobility problems to gain access without assistance. Home visits were also available.

Are services well-led?

Good

The practice was 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.High standards were promoted and owned by all practice staff and teams worked together across all roles. The leadership, management and governance of the practice ensured the delivery of high quality, patient centred care. The service was proactive and effectively anticipated and responded to change. There were systems in place to monitor and improve quality and identify risk. The patient participation group (PPG) was active and worked in close partnership with the practice. The practice sought feedback from staff and this had been acted upon. Staff and patients were encouraged to make suggestions for improvement and we saw evidence that suggestions were acted on. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.Staff we spoke with felt valued and were supported through regular meetings with managers, team meetings and appraisals, however we noted there had not been a full practice meeting where all staff were involved.

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 patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, for dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. The practice had recently appointed a liaison nurse for the care of older people. They completed healthy living checks on the elderly housebound and acted as a liaison point between the practice and other care providers to help supervise and coordinate complex care plans. The practice also supported patients at several care homes. Carers were highlighted on the practice's computer system and were given information about the local carers support team. The practice used computerised risk stratification tools to identify patients at risk including those at risk of hospital admissions. The practice worked closely with multidisciplinary teams to plan care accordingly.There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics included diabetic reviews, blood tests and the practice also offered blood pressure monitoring.

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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review with the practice nurse and then with the GP to check that their health and medicine needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice maintained a register for all major long term conditions. Patients with palliative care needs were supported using the Gold Standards Framework.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Summary of findings

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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. The patient participation group undertook a survey of young people to ascertain their knowledge of the services provided by the surgery and an information leaflet was created in response to the findings. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered contraceptive advice and coil fitting. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day.

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 a travel clinic for advice and vaccinations, which included yellow fever. The practice ran day and evening smoking cessation clinics and offered NHS health checks. The patient participation group had conducted a survey of young people registered with the practice and had involved the local community college. The survey looked at how accessible general medical services were to young people, how to access sexual health advice for help or guidance and where to gain help for mental health issues. A comprehensive Young People's Health Guide was produced in response to the results.

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

Summary of findings

those with a learning disability and supported patients living at two homes for residents with learning disabilities. GPs carried out annual health checks and where necessary the practice offered longer appointments for vulnerable patients. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. There was information for vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. The practice provided a room for a local organisation who could signpost carers to relevant 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). Patients with severe mental health needs had care plans and received annual physical health check. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice provided information for patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice had an in-house counsellor which GPs could refer to or patients could self-refer. GPs at the practice had attended training on the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received three comment cards which contained positive comments about the practice. We also spoke with eight patients on the day of the inspection.

We reviewed the results of the national patient survey from 2013 which contained the views of 118 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 85% of respondents with a preferred GP usually get to see or speak to that GP, 87% of respondents described their experience of making an appointment as good and 93% of respondents described their overall experience of this surgery as good. All of these scores were well above the average local clinical commissioning group results.

We viewed the practice patient survey results from 2012. The findings indicated that over 93% of respondents thought the GP was good or very good at giving them enough time and listening to them. The survey also indicated that 87% of patients had complete confidence and trust in the GP they saw.

We spoke with eight patients on the day of the inspection and reviewed three comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we reviewed were consistently positive. Some of the patients had been registered with the practice for a number of years and told us the practice had supported all of their family members. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were friendly, professional, helpful and efficient.

Areas for improvement

Action the service MUST take to improve

- Review how patients are informed regarding medicine dose changes following blood test results and to follow national guidance.
- Review the management of the repeat prescribing system to ensure all staff are aware of the practice policy not to issue repeat prescriptions over the telephone.

Action the service SHOULD take to improve

- Ensure that training records are updated when staff have completed training.
- Ensure that there is a full practice meeting which includes all members of staff

Heathfield 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, a Practice Manager specialist, pharmacy specialist and a CQC compliance manager.

Background to Heathfield Surgery

The Heathfield Surgery is a semi-rural practice which offers general medical services to the population of Wealden area. The practice has a smaller branch surgery (The Firs Surgery) which we did not inspect. The practice is involved in the education and training of doctors and is also able to dispense medicines to it patients. There are approximately 12,260 registered patients.

The practice is run by seven partner GPs. The practice was also supported by a salaried GP, four practice nurses, two healthcare assistants, a team of receptionists, administrative staff and a practice manager.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from two location:

The Heathfield Surgery

96-98 High Street, Heathfield, East Sussex, TN21 8JD

and

The Firs Surgery

Little London Road, Cross in Hand, TN21 0LT

However, we only inspected The Heathfield Surgery.

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

The practice was a GP training practice and supported new registrar doctors in training. At the time of inspection there was one doctor who were receiving general practice training.

The practice population has a higher number of patients between 45 and 85 years of age than the national and local CCG average, with a significant higher proportion of 65-69 year old than the national average. There are a higher number of patients with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is significantly lower than the average for England.

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 carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the

Detailed findings

legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the NHS High Weald, Lewes, and Havens clinical commissioning croup (CCG). We carried out an announced visit on 3 February 2015.

During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff. We observed staff and patients interaction and spoke with eight patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed three comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events were discussed at the partner's monthly meeting and a dedicated meeting was held bi-monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw records for incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, the practice had incorrectly organised a referral that was not needed. This was investigated and the referring doctor had incorrectly organised this under the wrong patient's name. The patient was apologised to and an explanation given. The incident was discussed and actions recorded to prevent the same incident from happening again.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings and if needed during one to one 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 children, young patients and vulnerable adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level 3 safeguarding children training). Staff could demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding leads were and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, could be asked to be a chaperone. All staff undertaking these duties had received a criminal records check through the Disclosure and Barring Service. We saw there were posters on display within the clinical rooms which displayed information for patients about how to request a chaperone.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young

people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

The practice was a dispensing GP practice and provided medicines from their own dispensary for approximately 30% of their registered patients.

We checked medicines stored in the dispensary, treatment rooms medicine refrigerators and emergency medicines 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. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. Records of when checks were conducted were kept, highlighting medicines that were to expire soon. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber.

There was a system in place for the management of high risk medicines. Appropriate action was taken based on the results however, the system used (informing patients by telephone) was not in line with national guidance. It is safe practice for all dose changes to be confirmed in writing by the prescriber. (National Patient Safety Agency – Alert 18).

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We checked a small sample (20) of repeat prescriptions slips received on the day and noted two of them indicated that the medicine asked for had a review date from summer 2013. The practice nurse manager explained that this was often a problem as patients did not come in to the surgery when asked for a review.

The practice held stocks 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.

Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. We saw that medicines for destruction were stored safely. However, we noted the policy did not contain the name of the authorised person to contact to organise the destruction.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was working in practice. We were told that on occasions the staff took verbal instructions for repeat prescriptions over the telephone. This was against their own policy which says repeat prescription must be on line, in writing or using the repeat prescription slips.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw the last such assessment which was awarded.

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

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 lead 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 and that any improvements identified for action

were completed in a timely manner. However, we noted that although some improvements identified had been actioned, we found this information or the date it had been completed, had not been recorded.

An infection control policy and supporting procedures were available for staff to refer to including a policy for needle stick injury. This enabled staff 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.

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 bacterium that can grow in contaminated water and can be potentially fatal).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 weighing scales, spirometers and blood pressure measuring devices.

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. The practice manager told us that the practice had considered whether administration and reception staff should have a criminal check through the Disclosure and Barring Service (DBS). The decision had been taken that this was not necessary. However, we noted there was no written risk assessment supporting this discussion. No administration or reception staff were used as chaperones.

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 system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff 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.

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, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included on risk logs. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that most staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Requires improvement

Are services safe?

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 medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff 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 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.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. For example, one of the partner GP was the lead for supporting the nurses and healthcare assistants.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

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

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management.

The practice showed us eight clinical audits that had been undertaken. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit had taken place following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a potentially serious drug interaction between two specific medicines. The first audit demonstrated that 76 patients were receiving both medicines. The information was shared with GPs and patients were called for a medicine review. A second clinical audit was completed one year later where it was found that ten patient were identified as on the inappropriate combination. These patients had subsequently been reviewed and prescriptions altered. A further audit was planned in six months' time. Other examples included audits of cervical screening, urinary tract infections and early referral of suspected cancer.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit reviewing a medicine commonly used in the treatment of rheumatic diseases. Patients taking this medicine require a regular blood test to ensure safe prescribing. Following the audit, the GPs were able to carry out blood tests for the small number of patients who had not completed a blood test in the required time frame, in line with the guidelines. We noted that reception staff were able to schedule reminders for blood tests required.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 92% of patients with diabetes had a record of retinal screening in the preceding 12 months. We also noted that 94% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional in the preceding 12 months and 91% of patients with schizophrenia, bipolar affective

Good

Are services effective?

(for example, treatment is effective)

disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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 quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. 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 and, where they continued to prescribe it, outlined the reason why they decided this was necessary. 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.

The practice provided an enhanced service to patients who were most likely to be subject to unplanned hospital admissions. Patients were highlighted on the practice computer system so that their care could be prioritised.

Effective staffing

We looked through training records for staff and noted that some training was not up to date. Most staff had completed training in basic life support, fire awareness and safeguarding children. Staff we spoke with told us of the training they had completed but this was not always reflected in the practice's training plan. We spoke with the practice and deputy practice manager in relation to this. They were aware that some staff had not presented them with past training certificates and therefore the training plan had not been updated accordingly and possibly did not reflect the full training completed. Because of this they had put in place a training schedule which highlighted potential gaps in staff training. We saw that training dates and guest speakers for training had been arranged to ensure that all staff were up to date with their training requirements. For example, staff had access to on line information governance training and were expected to complete this by a required date. We also saw that a separate training session with a guest speaking had also been organised for all staff, to reinforce their knowledge.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example two staff members told us they had been supported to undertake NVQ's in their field of work. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback about this from the registrar 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, on administration of vaccines, travel health and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were 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 manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Relevant staff were aware of their responsibilities 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 identified 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, palliative care meetings every two months to discuss those patients with end of life care needs. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented. Staff felt this system worked well.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that 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. Staff we spoke with highlighted how patients should be supported to make their own decisions and how this would 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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures written consent was required and a patient's verbal 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

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted 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 opportunistic offering smoking cessation advice to smokers and reminding patients who were overdue cervical screenings.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that nearly 50% of patients in this age group took up the offer of the health check.

The practice had numerous 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 patients with a mental health problem and 55 out of 66 had seen a GP for an annual review.

The practice had identified the smoking status of 82% of patients over the age of 16 and we noted that 100% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 91% of children aged below 24 months had received their mumps, measles and rubella vaccination. The practice's performance for cervical smear uptake was 80%, which was comparable with other practices nationally. There was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

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 and a survey of 175 patients undertaken by the practice's patient participation group (PPG). 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 'among the best' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 95% saying the GP gave them enough time.

We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. 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 completed CQC comment cards to tell us what they thought about the practice. We received three completed cards and all were positive about the service experienced.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. In response to patient and staff suggestions, the practice was considering installing a glass partition between the reception desk and the downstairs waiting room.

Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view. We noted that patients were able to request to discuss private matters away from the reception desk and there was a privacy slip for patients to write confidential information to give to reception staff if they wished.

Care planning and involvement in decisions about care and treatment

The patient survey group area. The results from the practice's own satisfaction survey showed that over 93% of patients said they were sufficiently involved in making decisions about their care.

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

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

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 89% of practice respondents said the GP involved them in care decisions and 95% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local clinical commissioning

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 practice and rated it well in this area. The results of the national GP survey showed that 95% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 94% of patients said the nurses were also good at treating them with care and concern. The patients we spoke with on the day of our

Good

Are services caring?

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

Notices in the patient waiting rooms, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown an information board in the waiting area which contained information for carers to ensure they understood the various avenues of support available to them. Staff also told us about a 'carers' open day run with the patient participation group to ensure carers were aware of the services available to them.

Staff told us that if families had suffered a bereavement, their usual GP would contact them and if needed arrange a home visit. Staff could also arrange a patient consultation at a flexible time and would give them advice on how to find support services.

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 practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice's patient survey highlighted the need to advertise the nurse's expertise to patients. We saw that the patient participation group had created a leaflet for patients highlighting the services the nurses provide. The survey also requested that some of the chairs in the waiting area be raised to help less mobile patients. We noted that waiting areas contained raised chairs and chairs with arm rests to help aid patients.

The practice had a register of housebound patients. The register ensured the practice was aware when these patients had medicine requests, required home flu jabs, annual reviews or care planning. The practice had recently appointed a liaison nurse for the elderly. Who completed healthy living checks on the elderly housebound and acted as a liaison point between the practice and other care providers to help supervise and coordinate complex care plans. The practice also supported patients at several care homes. Carers were highlighted on the practice's computer system and were given information about the local carers support team.

The practice supported patients with both complex needs and those who were at high risk of hospital admission. The practice worked closely with local multidisciplinary teams and created personalised care plans to support patients to remain healthy and in their own homes. Patients with palliative care needs were supported. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term condition had their health reviewed in an annual review. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health.

The PPG had conducted a survey of young people registered at the practice. The survey was used to gauge the understanding of health services provided to young people living in the area. The survey was championed by a young person representative of the PPG and involved the local community college. The survey looked at how accessible general medical services were to young people, how to access sexual health advice for help or guidance and where to gain help for mental health issues. The results were published on both the practice and PPG website and as a result of the findings a comprehensive Young People's Health Guide was produced.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required. The practice website also had the functionality to translate the practice information into approximately 35 different languages. We noted that some staff had received equality and diversity training and that there was a policy to support staff.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was situated on the ground and first floor of a purpose built building. There was a lift which allowed access to the first floor. We noted patients had access to the front entrance of the practice via a slope and doors which had an automatic opening mechanism. Patients with restricted mobility could easily enter the practice and had level access to reception. Waiting areas were available both on the ground floor and on the first floor, these were accessible for patients who used wheelchairs and parents with prams. Accessible toilet facilities including baby changing facilities were available for all patients attending the practice.

Access to the service

Appointments were available from Monday to Friday 8am to 12.30pm and 2pm to 6.30pm. The telephone lines remained open during the lunch period. There was a late evening surgery on a Monday from 6.30pm to 8:00pm and an early morning surgery on Tuesday, Wednesday and Friday from 7am till 8am. Appointments were able to be booked on the day or up to two weeks in advance.

Comprehensive information was available to patients about appointments on the practice website. This included

Good

Are services responsive to people's needs?

(for example, to feedback?)

how to arrange urgent appointments and home visits and how to book appointments through the website and each GP's surgery times. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits could be arranged and GPs visited several local residential and care homes.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. All the patients we spoke with on the day told us they had been able to get appointments at a time convenient to them. During the inspection we noted one patient present at the practice for an opportunistic appointment and was able to see a nurse within 20 minutes of arriving. We also saw another patient had come in to pick up a prescription and the receptionist saw that there was a request for the patient to make an appointment with the doctor. We saw the patient was offered an appointment and saw the doctor within half an hour of attending the practice.

Data from the national patient survey indicated that 94% of respondents said the last appointment they got was convenient**.** On the day of inspection we asked staff when the next available appointment would be for a fasting blood test and a cervical screening appointment with the nurse. We were told that an appointment for the blood test could be booked for the following morning at 9am and an appointment with the nurse for three working days' time.

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 and was displayed in the waiting room and the practice had a leaflet available. We also saw there was a leaflet by the patient participation group (PPG) which gave information to the patient about the way that the PPG and other organisations could support them regarding their complaint, for example, NHS England. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at ten complaints received in the last 12 months and found these were handled, in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a no blame culture in the practice and felt that senior staff members were always available to talk with. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included aims and objectives of the practice. For example, the practice was committed to providing a comprehensive, high-class service to patients aiming to improve the health, well-being and lives of those cared for.

We spoke with 15 members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Many of the staff had worked at the practice for a number of years and spoke very positively about the practice. They told us there was good team work and they were actively supported to provide good care for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at some of these policies and procedures and found these were up to date and contained relevant information for staff to follow. This included whistleblowing, complaints, equality and diversity, chaperoning and safeguarding children.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner GP was the lead for safeguarding. We spoke with 15 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly meetings to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, coil changes within the clinically safe time period, cervical screening and antibiotics used for urinary tract infections.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us risk logs, which addressed a wide range of potential issues. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw that risks had been accessed for lone working, visitors to the practice and slips, trips and falls.

The practice held regular meetings which discussed performance, quality and risks. Clinical audits and significant events were also discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. However, some staff we spoke with told us the practice had not had a meeting where all practice staff attended. They told us they felt this would be useful for the formal sharing of information amongst the team but felt that information was shared on a more casual basis.

Leadership, openness and transparency

Staff told informed us that meetings were held regularly and we saw minutes of these meetings. For example, the GP partners held monthly meetings where discussions were had on management issues including succession planning and Quality Outcomes Framework (QOF) data. Weekly meetings were held to discuss things such as operational issues and risk assessments. We saw there were also quarterly meetings for nursing staff and for staff from the dispensary. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time not just at team meetings. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

The deputy practice manager was responsible for human resources including the policies and procedures. We reviewed a number of policies, for example grievance policy, induction policy, management of sickness which were in place to support staff. We were shown the staff

Are services well-led?

Good

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

handbook that was available to all staff, which included sections on equal opportunities, stress and a blame free culture. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. Staff we spoke with told us that patients had complained about the music playing in the waiting area. Some patients found it meant they could not hear patients being called through into GP surgeries via the tannoy. In response to this the music was tuned off and GPs who were aware of patients who may have a hearing impairment now collect their patients from the waiting area.

The practice had an active patient participation group (PPG) which worked in partnership with the practice. The PPG had conducted a survey of young people registered at the practice. The survey was used to gauge the understanding of health services provided to young people living in the area. The survey was championed by a young person representative of the PPG and involved the local community college. The survey looked at how accessible general medical services were to young people, how to access sexual health advice for help or guidance and where to gain help for mental health issues. The results were published on both the practice and PPG website and as a result of the findings a comprehensive Young People's Health Guide was produced. We saw this leaflet was available at the practice and through the websites.

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 we spoke with told us they had suggested moving staff who answer the telephone lines, to be away from the reception desk to ensure patient privacy. We noted this had been acted upon and calls were taken in a separate office.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with told us they would have no concerns in using the policy to protect patients if they thought it necessary.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had regular training either organised with the local clinical commissioning group or by the practice. Two staff members told us they had been supported by the practice to attain NVQ's in their field of work.

We looked through training records for staff and noted that some training was not up to date. Most staff had completed training in basic life support, fire awareness and safeguarding children. Staff we spoke with told us of the training they had completed but this was not always reflected in the practice's training plan. We spoke with the practice and deputy practice manager in relation to this. They were aware that some staff had not presented them with past training certificates and therefore the training plan had not been updated accordingly and possibly did not reflect the full training completed. Because of this they had put in place a training schedule which highlighted potential gaps in staff training. We saw that training dates and guest speakers for training had been arranged to ensure that all staff were up to date with their training requirements. For example, staff had access to on line information governance training and were expected to complete this by a required date. We also saw that a separate training session with a guest speaking had also been organised for all staff, to reinforce their knowledge.

The practice was a GP training practice and supported new registrar doctors in training. At the time of the inspection the practice had one GP registrar. One of the GP partners supervised the doctor at all times.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, a significant event was recorded for an electrocardiogram (ECG) result that was scanned to an incorrect patient. An ECG is commonly used to detect abnormal heart rhythms and to investigate the cause of chest pains. The practice investigated the event and discussed this with the appropriate team members. It was

Are services well-led?

Good

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

recorded that the new procedure was to place an identifiable label on the front of each ECG report so when scanned the patient details would be clearly displayed. Staff we spoke with told of this new process.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered provider did not protect people against the risks associated with the unsafe use and management of medicines because appropriate arrangements were not in place for informing people of changes to medicines and the repeat prescription policy was not always being adhered to. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.