The Practice Willow House

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of The Practice Willow House on 28 April 2015.

The practice has an overall rating of good.

The Practice Willow House provides primary medical services to people living in the Lower Bevendean region of Brighton and Hove. At the time of our inspection there were approximately 1977 patients registered at the practice with one salaried GP and locum cover. The practice was also supported by a nurse, a healthcare assistant and a team of reception and administrative staff.

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:

- 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.
- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information in relation to patients who were vulnerable.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles, with the exception of chaperone training for administrative staff. 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.

Summary of findings

- The practice had responded to concerns from patients about not being able to get appointments, and a high level of non-attendance by developing a same day only appointment system. They had implemented online appointment booking for patients unable to call in and this was working well for the majority of patients we spoke with.
- 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.
- Patients with palliative care needs were supported using the Gold Standards Framework.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

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

Importantly the provider should;

- Ensure all staff acting as chaperones have received appropriate training.
- Ensure that repeat prescribing protocols are reviewed and shared with all GPs.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or below average in some areas and above average in others 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 have 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. Patients were cared for by one salaried GP and one long term locum GP which allowed for continuity of 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 some aspects of care, including finding it easy to get through to the practice by phone. 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 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.

Summary of findings

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. 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 and we saw there were plans in place to develop new premises. Home visits and telephone consultations 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, including locality managers and a central clinical governance team. Staff felt supported by management. The priority for the practice was provision of high standards of care, patient involvement and promoting healthy lifestyles. The leadership, management and governance of the practice assured 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 practice sought feedback from staff and patients and this had been acted upon. Staff were encouraged to make suggestions for improvement and we saw evidence 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.

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. Patients had a named GP which allowed for continuity of care. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed, for example their QOF score for diabetes was 66%, for hypertension 57%, yet they scored 100% for rheumatoid arthritis, heart failure and atrial fibrillation. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice identified patients at risk including those at risk of hospital admissions and developed care plans involving the patient, their family and carers. Multidisciplinary meetings were held to discuss patients and the practice worked closely with the proactive care team to plan care accordingly.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 diabetic and end of life care. The surgery also had a community volunteer 'Navigator' who would signpost elderly patients to relevant services such as voluntary organisations like age concern. The practice was responsive to the needs of older people, and offered home visits and telephone appointments for patients who found it difficult to get into the surgery. The practice also provided a weekly service to the local nursing homes and provided individual patient reviews according to need. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients and the practice were in the process of inviting patients aged 78 and 79 for a shingles vaccination.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice nurse had a lead role and was trained in chronic disease management, including asthma, chronic obstructive pulmonary disease (COPD), and diabetes. Patients at risk of hospital admission were identified as a priority and the practice monitored the Urgent Care Dashboard regularly to identify patients using Accident and Emergency services. 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. Patient records were flagged so that GP's were aware when a patient had a care plan in place.

Summary of findings

Patients with palliative care needs were supported using the Gold Standards Framework and a register was kept of these patients.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

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 who were at risk. Immunisation rates were good for all standard childhood immunisations, although better (90%) for children up to 2 years than those up to 5 years (70%). Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice would refer pregnant women to a midwife and share their care during the pregnancy. Appointments were available outside of school hours and the premises were suitable for children and babies. There were children's activities available in the waiting area of the practice. 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 and processes to follow were clearly visible on notice boards in staff areas. 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 practice acknowledged that their open hours would not always meet the needs of working age people due to it being a single handed practice and the majority of appointments were 'on the day' appointments which the practice felt met the needs of the majority of their patients. However, the practice participated in a government scheme called EPIC so that patients could be offered appointments every evening until 20.00 and between 09.00 and 14.00 at weekends. The scheme was a locality scheme where patients would see a GP at another practice in the locality. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this age group. Patients could be referred to smoking cessation and for weight management and healthy eating advice.

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

those with a learning disability. GPs carried annual health checks for people with a learning disability 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 people. It had told vulnerable patients about how to access various support groups and voluntary organisations. The practice worked closely with community navigator volunteers who attended the practice patient participation group meetings and provided links in the local community. These community navigators worked particularly with vulnerable patients in the community to signpost them to relevant services and support them in accessing the care and support that they needed. 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. 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.

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 at risk of dementia and those with dementia were flagged on the practices computer system and had an annual review. Patients with severe mental health needs had care plans where both physical and mental health was assessed as well as annual reviews. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and we saw that 88% of annual dementia reviews had been carried out at the time of our inspection. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. We were told that there was a 6 week waiting list for talking therapies within the local community but that the community mental health team were often able to see patient's on the day if the referral was urgent.

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 41 comment cards which contained positive comments about the practice. We also spoke with four patients on the day of the inspection.

We reviewed the results of the national patient survey which contained the views of 81 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 81% of respondents found the receptionists helpful, 82% said that the last appointment they got was convenient and 91% had confidence and trust in the last GP they saw or spoke to.

We spoke with four patients on the day of the inspection and reviewed 41 comment cards completed by patients in the 2 weeks before the inspection. The patients we spoke with and the comments we reviewed were mostly positive. Comments about the practice included that patients felt they were treated with dignity and respect, that they were listened to, that the staff were pleasant and helpful, and that they are able to get appointments when they needed them. A small number of patients (3) stated they didn't like the new appointment system where they could only get appointments on the day, however the practice had set up this system following an audit of appointment attendance and for the majority of patient's this seemed to work well.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff acting as chaperones have received appropriate training.
- Ensure that repeat prescribing protocols are reviewed and shared with all GPs.

The Practice Willow House

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Practice Willow House

The Practice Willow House offers general medical services to people living in the Lower Bevendean region of Brighton and Hove. It is a single handed practice with one salaried GP and there are approximately 1980 registered patients.

The practice was run by The Practice Group. The practice was supported by central management functions from the head office, including human resources, health and safety and clinical locality leads. The practice was also supported by one salaried GP, a long term locum GP, a nurse, healthcare assistant and a team of receptionists. Operational management was provided by the practice manager.

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

Services are provided from:

The Practice Willow House

50 Heath Hill Avenue

Lower Bevendean

Brighton

BN2 4FH

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

The practice population has a higher number of patients under the age of 18, compared with the England average but comparable with the CCG average. The practice population also has a higher number of patients claiming disability allowance compared with the England and CCG average, plus a higher percentage of unemployment and percentage of patients with a long standing health condition.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Brighton and Hove Clinical Commissioning Group

Detailed findings

(CCG). We carried out an announced visit on 28 April 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, healthcare assistants and administration staff.

We observed staff and patients interaction and talked with four patients. We also spoke with a member of the patient participation group. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 41 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.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that incidents were reported on the online system via the practice intranet and all staff we spoke with had a good understanding of this process.

We reviewed safety records, incident reports and minutes of meetings where incidents were discussed for the last year. 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, incidents and accidents that had occurred during the last year and we were able to review these. Significant events were discussed at practice meetings and we saw that this included a review of actions and learning from significant events and complaints. The company also reviewed incidents reported centrally at head office and collated these so that trends and patterns could be identified and action taken to address this. The practice manager also met with the patient participation group (PPG) to ensure their input into learning from significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

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 tracked one incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we viewed details of a delayed referral due to a locum GP not following it up and we saw that this was addressed with the individual locum, but also used to update guidance for locums in relation to their responsibilities in making prompt and timely referrals.

National patient safety alerts were disseminated by the practice manager via email to practice staff. These were also received directly by the GP's. 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 practice 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, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and flow charts of action to be taken were visible in office and treatment areas. There was also information visible for patients in the waiting area relating to concerns about abuse and this included relevant contact numbers for people to report concerns.

The practice had appointed the lead GP as lead in 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). All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. We viewed the results of an internal safeguarding audit where staff had been questioned about access to information about safeguarding, indicators of abuse, and who to contact in and out of hours. The audit demonstrated 100% compliance with the practice's safeguarding policies and procedures.

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.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. 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, had been trained to be a chaperone. Some receptionists had also undertaken chaperone duties but we were told they had not received specific training in this, although staff we spoke with appeared to understand their responsibilities when acting as chaperones. 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 waiting room which displayed information for patients.

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.

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. Staff were able to tell us of an example of where there had been a problem with a medicine refrigerator. The action they had taken to ensure the safety of medicine storage included transferring vaccinations from one fridge to another.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

There were comprehensive medicines management policies in place. GPs took ownership of their own patient repeat prescription requests and patient medicines reviews and we were told they were organised by individual GP's in line with the National Prescribing Centre guidance. There was a protocol for repeat prescribing which was in line with national guidance, although this had not been reviewed by the current GP in post and locum GP's were not familiar with written guidance in operation within the practice. However, in line with national guidance, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. Blank prescription forms were stored securely and were tracked through the practice in accordance with national guidance.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives that had been signed by the lead GP and nursing staff to evidence that nurses had received appropriate training to administer vaccines.

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 contract with an external cleaning company which specified the cleaning requirements and frequencies. We observed that this was checked on a regular basis and any issues that had arisen had been brought to the attention of the cleaning company.

The practice had a lead for infection control. They had attended infection control training and attended regional infection control meetings and lead nurse meetings with colleagues within The Practice group where infection control was discussed. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out infection control audits. The results had been recorded and used to monitor any improvements identified and these were discussed at meetings.

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.

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.

We spoke with the practice manager regarding the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings) and saw that this had been carried out.

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. We saw evidence of calibration of relevant equipment and pat testing had last been completed in the past 12 months.

Records showed essential maintenance was carried out on the main systems of the practice. For example, fire safety equipment was serviced annually by an external contractor. Panic alarms were available via the computer system in all consulting and treatment rooms in case of emergency. All staff would respond if a call was raised.

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 there were suitable numbers of staff on duty and that staff rotas were managed well. The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. Staff we spoke with told us they were flexible in the way they worked to meet the needs of patients. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice was reliant on locum GP cover and we saw that appropriate checks were carried out and information available for locums to ensure they operated within practice guidelines.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice manager was the lead for health and safety and a health and safety policy was produced by head office and available via the practice intranet. A local health and safety policy was also available.

We saw that any risks were discussed practice meetings. For example, we saw notes relating to action taken as a result of incidents including discussions held at practice meetings. We also saw that examples of good practice were discussed and learning cascaded in relation to safety and responding to risk

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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.

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

Good

Are services safe?

the practice. Risks identified included power failure, staff shortage and access to the building. We saw an example where the business continuity plan had been implemented effectively due to GP shortages and sickness.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they 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 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 nurse working at the practice specialised and was trained in specific chronic disease management that included diabetes, heart disease and asthma. The healthcare assistant carried out patient health checks. They regularly assessed patients during appointments to help them manage their conditions and to offer advice and support. Patients with learning disabilities and with poor mental health received annual health checks. Patients eligible for flu vaccinations were identified and encouraged to attend the practice to receive them. The practice monitored their performance in this area and had taken action to improve uptake for eligible patients.

There was an effective system in place for the effective management of patients requiring cervical smear tests. Patients were invited to book an appointment. A system was in place for dealing with abnormal results that included contacting the patient and arranging a follow-up appointment with a GP. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw that learning from educational meetings attended by individual staff was cascaded at practice meetings or through printed information available in staff areas. For example we saw that regional meetings were held at different levels within the practice locality, such as the nurses from each locality practice would meet with the regional lead nurse and share learning.

The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or patients with long term conditions. 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 and review, scheduling clinical reviews and medicines management.

The practice had a system for completing clinical audit cycles. Examples of clinical audit included an audit of smear which lead to suggested changes to practice and further training for staff, and an audit of the treatment of urinary tract infections tests lead to increased knowledge and awareness to improve practice. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 81.3% of patients with diabetes, on the register, had a record of retinal screening in the preceding 12 months. We also noted that 100% of patients with atrial fibrillation had been assessed for stroke risk in the preceding 12 months and that 72.7% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months. The practice met all the minimum standards for QOF in asthma/atrial fibrillation/epilepsy/heart failure/hypothyroidism/learning disabilities/rheumatoid arthritis. 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. We also saw that the lead locality GP for The Practice group undertook annual consultation reviews for the GP at the practice, reviewing a selection of consultations and identifying areas of good practice and development. The staff we spoke with discussed, as a group how 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, although this had not been reviewed by the current GP in post and locum GP's were not familiar with written guidance in operation within the

Good

Are services effective?

(for example, treatment is effective)

practice. However, in line with national guidance, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We were told 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 manager told us that that multidisciplinary meetings with specialist palliative care staff were held every 6 weeks using teleconferencing facilities. The GP was lead for palliative care and staff were alerted to a patient being on the register so that if the patient contacted the surgery they could respond appropriately. There was also a system in place to ensure up to date patient information was shared with the out of hours service.

The practice was involved in a proactive care project to care for patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were frail or most likely to be subject to unplanned hospital admissions. The proactive care project involved working within a cluster with other practices in the area and a stratification tool was being set up to identify patients. Patients were also highlighted on the practice computer system so that their care could be prioritised.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. The practice was a single handed practice, with 2 salaried GP's (including one locum). Recruitment of GP's had been problematic for the surgery and we saw this reflected in some of the feedback we received from patients. The practice manager had worked with The Practice group head office to work on recruitment and at the time of the inspection there was a stable GP team in place. Additional GP support was provided by a locality lead GP for The Practice group based in Brighton. The locality lead GP would provide support as necessary and would helped with a specific weekly clinic. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding training. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The nurse at the practice had the necessary skills, qualifications and experience to carry out their role. They were given time to undertake their continuous professional development to enable them to keep up to date with their skill levels. Nurses and healthcare assistants had received appropriate specialist training in delivering the services provided. These included managing patients with long term conditions such as asthma or diabetes, providing immunisations for children and adults, cervical smear testing and smoking cessation advice.

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.

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

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patient 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 generally worked well.

The practice had good working relationships with local pharmacies based within the practice locality. Benefits for patients included support around medication reviews and reminding patients to attend for follow up appointments.

The practice held multidisciplinary team meetings every 4 – 6 weeks to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, social workers, and palliative care nurses. The meetings were often held as teleconferences and staff we spoke with felt this system worked well.

Information sharing

The computerised patient record system was used to record all relevant details about patients on their records. This ensured all staff at the practice had timely information about a person's care and treatment.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. Electronic systems were also in place for making referrals. The practice made referrals through the Brighton and Hove Integrated Care Service (BICS). The BICS service provides a clinical review service and works to ensure patient referrals meet their needs, while providing peer review in relation to referrals. 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 One to coordinate, document and manage patients' care. All staff were fully trained on the system.

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 to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information. The lead GP provided training on the Mental Capacity Act 2005 and we saw that this was discussed at practice meetings. We saw records relating to a best interest meeting that the GP had been involved in relating to a best place of care decision for a patient of a care home that did not have the mental capacity to make their own decision.

Patients with a learning disability and those with dementia were recorded on a register and monitored regularly. We saw they were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, 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. Staff we spoke with demonstrated an understanding of the need to seek consent prior to carrying out a procedure, ensuring that patient's had a good understanding of what they were consenting to.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse 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. The practice also offered NHS Health Checks to all its patients aged 40-75. GPs we spoke with told us that

Good

Are services effective?

(for example, treatment is effective)

regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriate timed intervals.

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, the practice provided weight management advice, smoking cessation advice and support from a wellbeing counsellor. There were services in place for patient's to be referred to smoking cessation clinics outside of the practice and we saw information about these on posters in the waiting area. The practice also participated in a navigator service where a volunteer navigator was available to support patients in accessing community based services that were available to them. The volunteer navigator worked within the local community, spent time based at the practice and had attended patient participation group meetings.

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 all patients with dementia and we saw that 88% of them had attended a dementia review appointment in the preceding 12 months. Patients with a long term condition were offered regular health checks and we saw that additional support services were available. For example, as part of the practice health promotion programme, both the practice nurse and healthcare assistant were trained in smoking cessation management. The healthcare assistant provided weight management advice and would signpost patients to relevant services.

The practice's performance for cervical smear uptake was 83%, which was similar to national indicators. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

There was a clear policy for following up non-attenders by the named practice nurse. 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 all patients with a learning disability and invited them to yearly annual reviews. The practice had also identified the smoking status and alcohol consumption of patients with a physical or mental health condition. For example, 87.5% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of their alcohol consumption in the preceding 12 months.

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 90% of children aged below 24 months had received their mumps, measles and rubella vaccination.

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

Patients completed CQC comment cards to tell us what they thought about the practice. We received 41 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with four patients individually on the day of our inspection and we spoke with one member of the practice patient participation group (PPG). All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 74% of patients rated their overall experience of the practice as good, 82% of practice respondents said the GP was good at listening to them and 82% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 91% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 94% said the same about the last nurse they saw.

The practice collected and reviewed customer comments and suggestions and collated these into a report that incorporated action to be taken. We saw that some concerns from patients included aspects of the appointment system. We saw that in response to a high number of unattended appointments that the practice had switched to 'on the day' appointments only. This had successfully addressed the issues with non-attendance but had caused concerns for some patients. For example, patients who worked had difficulties phoning on the day to make an appointment so the practice set patients up with a log on for on line booking and repeat prescription requests.

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

We observed that staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The reception area and waiting room were separate which allowed for greater privacy for patients and we saw that patients were given the option of speaking with reception staff away from the main entrance to the surgery if they wished. We also noted that telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded generally 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 72% of practice respondents said the GP involved them in care decisions and 72% felt the GP was good at explaining treatment and results. The practice was working towards improving care planning for patients with long term conditions and mental health issues. For example, we saw on the day of our inspection that 93% of care plans and mental health reviews had been undertaken for patients on the register.

Patients we spoke to 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. We saw that patients with learning disabilities were offered an annual review with nursing staff. Patients we spoke with 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.

Good

Are services caring?

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

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 73% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 83% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when patients needed help and provided support when required.

Notices in the patient waiting room 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 saw information was available for carers to ensure they understood the various avenues of support available to them. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. We were informed that the GP would contact the family and when appropriate advice on how to access support services would be given.

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 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 had implemented an on the day appointment system in response to concerns from patients unable to get appointments when they needed them. The new appointment system had been implemented to improve accessibility to appointments and to cut down on non-attendance that had been high. Most patients we spoke with and who completed comment cards confirmed that appointments were accessible and we saw that staff had addressed the concerns of some patients around the new system.

A GP triaging system was in place. Longer appointments were available for patients who needed them and those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Working age patients were able to book appointments and order repeat prescriptions on line. The practice was able to access services through EPIC (Extended Primary Integrated Care) which meant that patients could access appointments on weekends and evenings through an extended hours service with other locality practices.

Patients experiencing poor mental health were supported by the GPs and local mental health teams. A mental health lead clinician oversaw patients with a diagnosis of depression or severe mental health problems. Patients with likely dementia were offered an annual review at the practice or at home with discussion with carers following diagnosis. We saw that the practice were involved in a system for assessing mental capacity and that the GP who lead on mental health had provided mental capacity training for practice staff. Patients could be referred to counsellors as needed and staff were aware of the availability support from the community mental health team.

The practice had a housebound register. The register ensured the practice was aware when these patients had medicine requests, required home flu jabs, annual reviews or care planning. The practice also supported patients who were resident in local care homes and we saw good evidence of GP involvement in supporting best interest decisions for patients who did not have mental capacity.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice were involved with the local proactive care team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists. Personalised care plans were produced and were used to support people to remain healthy and in their own homes. Patients with palliative care needs were supported using the Gold Standards Framework. They 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 a long term condition had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition and worked with community matrons, district nurses and proactive care team to provide support. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, dementia and severe mental health.

Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up.

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 provided equality and diversity training through an on-line training programme. The practice had policies for equality and diversity and we saw that the service was planned to meet the needs of individuals

The premises and services met the needs of people with disabilities. The patient areas within the practice were situated on the ground floor of a purpose built building.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients had level access to the front entrance of the practice. Patients with restricted mobility could easily enter the practice and had level access to reception. The waiting area was accessible for wheelchairs and mobility scooters. There were plans in place to relocate the practice into new premises although staff weren't sure when this was going to happen. We viewed comments from one patient about the lack of baby changing facilities and saw that the practice manager had responded to this stating that they had removed the facility due to health and safety concerns and that this would be tackled in the plans for re-development.

Access to the service

Appointments were available from 8.30am to 6pm on Mondays and Thursdays, 8.30 to 5pm on Tuesdays and Fridays, and 08.30 to 12pm on a Wednesday. Extended access appointments were available through an extended primary integrated care (EPIC) service where patients can see a GP in another practice during evenings and at weekends. Requests for urgent appointments were dealt with by a telephone triaging system where a doctor would call the patient to discuss the problem and arrange an appointment or provide advice as needed. Patients were asked to call the surgery before 10am for urgent appointments and home visits where possible, however practice staff told us they could still offer patients advice and appointments outside of this time if needed.

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

Longer appointments were also available for people 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 local 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. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. We noted data from the national patient survey indicated that 76% of respondents said were able to get an appointment to see or speak to someone the last time they tried and 82% 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 an emergency and a cervical screening. The appointment system showed that there was an emergency slot free for that afternoon and that they could also offer extended hours evening appointments through the EPIC service. We noted that the next cervical screening appointment with the nurse was for the following week.

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 There were posters in the waiting room to describe the process should a patient wish to make a complaint or provide feedback, including through a comments/suggestion box. Information was also advertised on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. We noted that lessons learned from individual complaints had been acted on. 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 culture of the practice was that of openness and transparency when dealing with complaints and the practice tried to encourage patients to share their opinions. We saw that the patient participation group (PPG) were involved in supporting the practice in evaluating issues raised from concerns and complaints and those regular meetings were held between the group, the practice manager and lead GP. One example we were given of changes made from

Good

Are services responsive to people's needs?

(for example, to feedback?)

concerns raised related to changes to access to appointments and providing alternative ways of booking appointments for patients who were unable to contact the surgery by phone.

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 provide high standards of care, involve patients in decision making about their treatment and care, promote healthy lifestyles and ensure continuous improvement of healthcare services.

We found details of the vision and practice priorities in their statement of purpose. The practice also aimed to treat patients with dignity and respect, ensure effective governance systems, continually educate and motivate staff, and ensure the quality of service through supervision and shared learning.

We spoke with 7 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about the practice and thought there was good team work with a good level of active support from senior staff. Staff described the culture of the practice as being supportive, positive and open to their suggestions and ideas. Many of the staff had worked at the practice for many years and told us it was a good place to work.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Policies were generated centrally by The Practice group head office and local policies were also in place within the surgery. We looked at some of these policies and procedures and found these had been reviewed annually, were up to date and contained relevant information for staff to follow. This included recruitment, medicine management, whistleblowing, complaints, business continuity, chaperoning and infection control.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was lead for safeguarding. We spoke with 7 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 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, audits in the preceding 12 months included cervical smears, treatment of urinary tract infections and GP and nurse consultation audits.

The practice had robust arrangements for identifying, recording and managing risks. The business manager showed us risk assessments, which addressed a wide range of potential issues, such as infection control, fire, COSHH (control of substances hazardous to health), and building maintenance.

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 in some areas, for example asthma, epilepsy, heart failure and palliative care. However, it was performing below national standards in other areas, for example cancer, chronic kidney disease and mental health. QOF data was discussed at monthly team meetings to maintain or improve outcomes and the practice demonstrated an improvement in their overall QOF score in the preceding 12 months. The GP told us they were focusing on areas for improvement and there was evidence of this, for example, in mental health care planning. The practice held regular meeting where performance, quality and risks had been discussed. Clinical audits and significant events were regularly 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.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were regular management / clinical meetings. Staff told us there was an open culture within the practice and they were happy to raise issues and felt encouraged to do so. The practice manager and clinical staff participated in group meetings with peers across The Practice group and there was support available for staff from regional leads within the group.

We saw there were a number of human resource policies and procedures in place to support staff, including equality and diversity, complaints and whistleblowing. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and

Are services well-led?

Good

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

knew the management of the practice and their clinical colleagues would take their concerns seriously. Staff we spoke with knew where to find these policies on the electronic system if required.

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

The practice had gathered feedback through patient surveys, complaints and feedback. There was an active patient reference group in operation. The group included representatives from a number of population groups including working age people, older people and those with long term conditions. Meetings were held every 3 months and we saw that there were opportunities for patients to participate 'virtually' via email if they were unable to attend meetings in person. Members of the group and practice staff told us that the group was involved in working with staff to review patient surveys, feedback and complaints. Members of the PPG had also participated in mock inspections of the practice used to assess and evaluate quality issues. We were told that one of the members of the patient reference group was also a local community development worker and would actively seek feedback from local people.

The practice had also conducted its own patient survey where questions had been designed with involvement from the patient participation group. Questions included specific issues relating to the practice, such as the impact of not having a regular GP.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and supervision. We looked at staff files and saw that regular appraisals took place and included personal development plans. 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, The Practice group or by the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted that staff had been involved in a review and discussion about a medical emergency that had occurred at the practice, in order to identify good practice and share learning.