Clarence Park Surgery

Quality Report

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Weston Super Mare
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Date of inspection visit: 11 February 2015
Date of publication: 25/06/2015

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 Clarence Park Surgery on 11 February 2015. Overall the practice is rated as Good.

Specifically, we found the practice was good for providing an effective, responsive, caring and well led service. They required improvement for providing safe services in relation to their medicines management. Overall they were good for providing services for all of the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was not always recorded, monitored, appropriately reviewed and addressed. For example, infection control audits did not always identify areas for improvement and significant events were discussed but had not always been recorded.
- Risks to patients were often assessed and well managed. However, there were some aspects that required improvements and review including medical emergencies, security arrangements.
- 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.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had 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.

We saw one area of outstanding practice:

- One of the nurses had achieved the Queens Nursing Institute in 2014. This award recognises a nurses commitment to the values of community nursing, to excellent patient care, and to a continuous process of learning and leadership. Locally, they were leading improvement projects and redesigning services to improve care for patients. The award was for the nurses development, teaching and examination of students undertaking a post graduate diploma/MSC at the university of Cardiff medical school. They also had an honorary contract as a Senior Lecturer at a Hospital in the Isle of Man where they facilitated and supported pre-registration learning and non-medical prescribing course. Additionally they were mentoring a nurse who had been a newly qualified in minor illness. The nurse was well established within the area and when they had moved to this practice other patients had joined this practice due to the quality of care received. They ensured patients were consistently seen to complete treatment and necessary tests in a timely manner.

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

Importantly the provider must:

- The practice must risk assess medical emergency equipment and medicines in reflection of current guidelines and review security of all medicines including vaccine refrigerators and where emergency medicines were kept.

Additionally the provider should:

- Review procedure for recording significant events to ensure these are recorded when they happen and any action to address the event.
- Review access to the front entrance of practice to improve accessibility for all patients.
- Review how consent was recorded for joint injections including any advice and guidance provided during consultations.
- Review and risk assess security of consultation rooms.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Lessons were learned and communicated to support improvement. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients who used services were assessed however, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, ensuring risk assessments were carried out to ensure the practice held adequate levels of emergency equipment and medicines.

Are services effective?

Good

The practice is rated as good for providing effective services. National data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had generally received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of recent appraisals and personal development plans for some staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. National data showed that patients rated the practice higher than others for some 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 saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of its local population and engaged with the NHS England Area Team, the Clinical Commissioning Group (CCG)and the local Primary Care Federation to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same

Summary of findings

day. The practice had adequate facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded appropriately to issues raised, however actions to address complaints were not always recorded. Learning from complaints was shared with staff.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We heard about examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students).

Summary of findings

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 offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. They had carried out annual health checks for patients with a learning disability and all of these patients had received a follow-up appointment where indicated. They offered longer appointments for patients with a learning disability where the need was identified.

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

People experiencing poor mental health (including people with dementia)

Good

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

We saw 100% of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. They had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

During our inspection we spoke with two patients visiting the practice and met with eight members of the patient participation group. We received 19 comment cards and one letter from patients who visited the practice and saw the results of the most recent patient participation group survey. We heard from staff who supported patients in local nursing and residential homes, they told us the practice provided prompt and positive support for these patients. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS National GP patient survey and the Care Quality Commission's information management report about the practice. We saw 96% of patients described their overall experience of this surgery as good during the 2014 National GP patient survey. Additionally 96% of patients completing the practices 'Friends and Family' test in December 2014 said they would recommend the practice.

Comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving compassionate care and treatment, about seeing a GP or nurse of their choice at most visits and about being treated with respect and consideration. Comments from patients also explained about the compassionate support they received by the GPs and nurses. There were two slightly negative comments, both were about access to appointments however, other patients commented favourably about appointment access.

We heard and saw how most patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. The most recent 2015 National GP patient survey showed 84% of patients found it easy to get through to the practice and 90% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to make appointments, 81% describe their experience of making an appointment as good.

Patients told us their privacy and dignity was respected at all times both during consultations and in the reception and waiting areas. They told us they found the reception area was generally private enough for most discussions they needed to make. The most recent 2014 GP survey showed 94% of patients said they found the receptionists at this practice helpful. Patients told us about GPs providing extra support to themselves and carers during times of bereavement. Many patients had been attending the practice for over 20 years and told us about how the practice had evolved, how they were always treated well and how the new premises had improved access to treatments. The GP survey showed 89% of patients said the last GP they saw or spoke with was good at giving them enough time and 98% stated they had confidence and trust in the last GP they saw or spoke with.

Patients told us the practice always appeared clean and tidy. Online repeat prescription facilities had been added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets.

The practice had a patient participation group (PPG) who met with practice staff and helped make suggestions about improvements to the services offered by the practice. We saw minutes of the last PPG meeting held on 29th January 2015. Members had made recommendations which had been addressed.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- The practice must risk assess medical emergency equipment and medicines in reflection of current guidelines and review security of all medicines including vaccine refrigerators and where emergency medicines were kept.

Action the service SHOULD take to improve

- Review procedure for recording significant events to ensure these are recorded when they happen and any action to address the event.
- Review access to the front entrance of practice to improve accessibility for all patients.
- Review how consent was recorded for joint injections including any advice and guidance provided during consultations.
- Review and risk assess security of consultation rooms.

Outstanding practice

- One of the nurses had achieved the Queens Nursing Institute in 2014. This award recognises a nurses commitment to the values of community nursing, to excellent patient care, and to a continuous process of learning and leadership. Locally, they were leading improvement projects and redesigning services to improve care for patients. The award was for the nurses development, teaching and examination of students undertaking a post graduate diploma/MSC at the university of Cardiff medical school. They also had an honorary contract as a Senior Lecturer at a Hospital in the Isle of Man where they facilitated and supported pre-registration learning and non-medical prescribing course. Additionally they were mentoring a nurse who had been a newly qualified in minor illness. The nurse was well established within the area and when they had moved to this practice other patients had joined this practice due to the quality of care received. They ensured patients were consistently seen to complete treatment and necessary tests in a timely manner.

Clarence Park 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 second CQC inspector and an expert by experience. Experts by Experience are people who have experience of using care services. They take part in our inspections of health and social care services.

Background to Clarence Park Surgery

Clarence Park Surgery, 13 Clarence Road East, Weston Super Mare, North Somerset, BS23 4BP is a small practice located close to the centre of Weston Super Mare.

Clarence Park Surgery has approximately 4,800 patients registered with the practice with a catchment area which includes an area within Weston-Super-Mare, there is a boundary outside which the practice cannot accept patients. There are three GPs employed by the practice, two partners and a salaried GP. Two of the GPs are female and one is male, the hours contracted by GPs are equal to approximately 2.1 whole time equivalent employees. Additionally there are five nurses employed by the practice including an advanced nurse practitioner; a health care assistant was also employed. One of the nurses had achieved the Queens Nursing Institute award in 2014. This award recognises a nurses commitment to the values of community nursing, to excellent patient care, and to a continuous process of learning and leadership. Locally, they are leading improvement projects and redesigning services to improve care for patients.

The practice population is predominantly white British with an age distribution of male and female patients predominantly in the 45 and above age categories. The average male and female life expectancy for the practice is 80 and 84 years respectively, slightly above the national average. The practice has the highest number of older patients over the age of 85 years in the South West with many of them living in nursing and residential homes. The patients come from a range of income categories with an average for the practice being in the fourth more deprived category. One being the most deprived and ten being the least deprived. About 15% of patients are over the age of 75 years and about 12% under the age of 15 years. Approximately 96% of patients described their overall experience of this surgery as good at the last National GP patient survey published in January 2015.

The practice has a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has core opening hours from 8:00am to 6:30pm to enable patients to contact the practice. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by BrisDoc and patients are directed to this service by the practice during out of hours.

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

Detailed findings

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the North Somerset Clinical Commissioning Group and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 11 February 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included two GPs, two nurses, one health care assistant, the practice manager and five administrative and reception staff. We spoke with two patients visiting the practice during our inspection, eight members of the patient participation group and received comment cards from 19 patients and a letter of comments from another patient.

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, where staff observed a patient being handled in a way which could have caused them harm.

We reviewed safety records, incident reports and minutes of meetings where these 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 very few records of incidents that had occurred during the last year and we were told they needed adding to the log. The significant event log provided to us recorded the type of event that had occurred but lacked detail of what was done and the learning identified. Significant events was a standing item on the weekly Monday practice meeting agenda but were not formally reviewed annually to identify themes and collective learning. However we heard 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 and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example, using the fire drill procedure where emergency situations occurred in the waiting room and purchasing mobile screens to ensure privacy in these circumstances. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by nurse practitioner to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at weekly 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 child protection and vulnerable adults. 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 for example, on the wall in the nurse practitioners room.

The practice had appointed a dedicated 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. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or where patients had mental health conditions which may affect their behaviour.

There was a chaperone policy, which was visible in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone and had a criminal background check through the disclosure and barring service.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely, the vaccine refrigerator and one of the medicines

cupboards containing emergency medicines and other general medicines was not routinely locked. The treatment room door where medicines were routinely kept was not locked. Within 24 hours of the inspection the practice had confirmed they had secured the medicines cupboard.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of patient directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and these were tracked through the practice. Prescriptions were generally kept securely at all times although we noted one GP left a pad of prescriptions, in a black wallet to make them less obvious, on their desk whilst completing administrative tasks following a patient consultation. This was removed immediately when noted by our inspection team.

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 to enable them to provide advice on the practice infection control policy and carry out staff training. The practice trained its staff on infection control by ensuring all staff had read the infection control policy and any updates from latest guidance were sent to relevant staff for review. We saw evidence that the lead had carried out an infection control audit in October 2014. Improvements have been identified for action. We noted pedal bins had been identified as being used throughout the practice, however, we observed on our inspection that open bins with no lids were used in patient toilets and treatment rooms.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during intimate or personal examinations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had completed a risk assessment in February 2015 to assess the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

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, electrocardiogram and blood pressure measuring devices. The practice used single use items for patient examinations and these were disposed of in line with practice policies.

Staffing and recruitment

We read two recruitment files which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate

professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, staffing and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw a fire risk assessment had been completed by the practice manager approximately in 2011. They had identified that a full review should be carried out by an external agency and had this booked in February 2015. We saw fire extinguishers had been regularly checked. There were two fire Marshall's who had last received training in July 2012 and were due to review this in July 2015. A recent fire drill had been completed by an external company. However, it was noted that fire alarms were not routinely tested.

We noted that there was no formal risk assessment for the security of consulting and treatment rooms because they were routinely kept unlocked when not used.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an adult oximeter. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. However, the practice did not have an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency) and had not carried out a formal risk assessment to determine the use of having an AED in reflection of the Resuscitation Council (UK) guidance for primary care, equipment and drug lists for cardiopulmonary resuscitation, dated November 2013.

Emergency medicines were available in the practice and all staff knew of their location. The cupboard where the emergency medicines were stored was unsecured. Once highlighted to the practice manager they arranged for a lock to be fitted to the cupboard. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. However, the practice did not have medicines to manage the treatment of collapse through Bradycardia (Bradycardia can be triggered by a number of health conditions and also coil fitting). We noted the Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists provided clinical guidance about which medicines should be provided in these circumstances in Appendix 4 of the Service Standards for Resuscitation in Sexual and Reproductive Health Services January 2013. The reason stated for not having this medicine by the partners and practice manager was the close proximity of the local ambulance station. We were assured that risks had been considered and staff knew how to manage this for example, by dialling 999 and calling for an ambulance. However a robust risk assessment had not been completed to justify why this medicine was not available in consideration to the guidance stated.

Processes were 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of utility companies to contact if the heating, lighting or water systems failed.

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

We saw data from the North Somerset Clinical Commissioning Group (NSCCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. 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 within two weeks or sooner by their GP according to the individual patients 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 of patients with suspected cancers who were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. Due to increase on practice demand and resource constraints routine referrals could be delayed due to length of time typing up the referrals. The practice were actively working to train additional members of staff to support this process.

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 managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last three years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, where patients had been prescribed oral nutritional supplements(SIP feeds). An audit was carried out to identify patients prescribed with SIP feeds. The changes implemented by both partners was they reviewed the patients notes to identify the reason sip feeds were started. Up to date weights were requested (several of the patients were in nursing or residential homes) and SIP feeds were stopped where appropriate if the patients had gained weight.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients newly diagnosed with diabetes had been referred to a structured education programme, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

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. 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. 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 implemented the gold standards framework for end of life care. They 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 had a strong relationship with a local hospice,with end of life care nurses attending monthly meetings in the practice. The practice tried to involve the end of life care nurses early when patients were nearing the end of their life to establish positive working relationships and assist in seamless transition of care when needed. As a consequence of these contacts and a better understanding of the needs of patients, the practice had increased the number of patients who had care plans in place.

The practice also participated in local benchmarking run by the North Somerset Clinical Commissioning Group (NSCCG). 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. For example, clinical indicators for asthma and chronic obstructive pulmonary disease (COPD).

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that the majority of staff were up to date with attending mandatory courses such as annual basic life support. However, other areas of training needed to be reviewed such as infection control to ensure understood their role in preventing the spread of infections. We noted a good skill mix among the doctors with two having additional diplomas in obstetrics and gynaecology and one with a diploma in geriatric medicine. 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).

One of the nurses had achieved the Queens Nursing Institute in 2014. This award recognises a nurses commitment to the values of community nursing, to excellent patient care, and to a continuous process of learning and leadership. Locally, they were leading improvement projects and redesigning services to improve care for patients. The award was for the nurses development, teaching and examination of students undertaking a post graduate diploma/MSC at the university of Cardiff medical school. They also had an honorary contract as a Senior Lecturer at a Hospital in the Isle of Man where they facilitated and supported pre-registration learning and non-medical prescribing course. Additionally they were mentoring a nurse who had been a newly qualified in minor illness. The nurse was well established within the area and when they had moved to this practice other patients had joined this practice due to the quality of care received. They ensured patients were consistently seen to complete treatment and necessary tests in a timely manner.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, basic life support and safeguarding children and vulnerable adults.

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

Good

Are services effective?

(for example, treatment is effective)

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. They 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. Staff knew their role 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 weekly and quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, hospital admission avoidance or children on the at risk register. These meetings were attended by community nurses, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice provided care and treatment to a number of patients who resided in 28 local nursing, residential, mental health and learning disabilities support homes. We spoke with a senior member of staff at six of the homes where they provided us with positive feedback about the service provided. They said they had a good relationship with the practice and the practice involved families regularly in decision making, where necessary. If patient's required urgent attention then this would be dealt with promptly alongside any repeat prescription requests.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made approximately 50% of referrals in December and January 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.

For emergency patients, there was a policy of providing a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the GPs and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. However the training records we saw did not indicate that staff had undertaken training in this subject.

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. The practice had approximately 200 care plans in place which had been reviewed. 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 GPs spoken with demonstrated a verbal 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). We saw Fraser competencies were also used when prescribing contraception to patients under the age of 16 years old.

Good

Are services effective?

(for example, treatment is effective)

There was a practice protocol for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was gained. We found consent was not always recorded in the patient's notes when the GP treated patients with joint injections, this included a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the 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. We noted a culture among the nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice made a wide range of information about health promotion and prevention available to patients in the waiting room. Information included subjects such as dementia, diabetes, wellbeing, diet and mental health. GPs and nurses also had a range of information they shared with patients as appropriate.

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 the majority were offered an annual physical health check. Practice records showed most had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered smoking cessation clinics to these patients each Tuesday afternoon. The practice had a 30% success rate for patients giving up smoking following attendance at these clinics. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84%, which was in line with others in the CCG area. 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 member of staff responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was about average for the CCG, and again there was a process for following up non-attenders.

Population groups evidence

The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. All had up to date care plans and these were shared with other providers such as the out of hour's service. All older patients discharged from hospital had a follow-up consultation where this was clinically advised.

The practice was proactive in supporting its older patients by providing fortnightly ward rounds at the two local nursing homes in addition to liaising regularly with a large number of residential homes in the area. The practice met regularly with residential home support teams, promoted repeat dispensing for patients on multiple medicines and supported the use of dosette boxes to help improve medicines adherence.

The practice provided annual reviews for patients diagnosed with various long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. Data from the 2013/14 Quality and Outcomes Framework (QOF) showed 98% of patients diagnosed with diabetes received an annual influenza injection. The practice had adopted the use of summary care records for their most vulnerable patients in this category. We saw the nurses had been actively promoting healthy lifestyles with patients. Information leaflets were available in the consulting rooms and advice offered was recorded in the patient's notes.

The practice provided nurse led clinics for patients with asthma, COPD, cardiovascular disease, hypertension and diabetes and all patients with these diagnoses were encouraged to attend these clinics. Full details of the days these clinics were held were on the practices website.

Good

Are services effective?

(for example, treatment is effective)

Immunisation rates for all standard childhood immunisations were around average for the CCG and up to 100% for some common vaccinations such as polio and diphtheria. We saw evidence of signposting young people towards sexual health clinics and contraception advice in information around the practice.

Patients of working age had access to a range of clinics and services in the practice. The uptake rate for cervical smears for women aged 25 to 65 whose notes recorded that a cervical screening test has been performed in the preceding 5 years was about 83.7%. A range of additional in-house services including, phlebotomy (blood tests), spirometry (a test that can help diagnose various lung conditions), international normalized ratio (INR) blood tests monitoring and NHS health checks were provided.

The practice held a register of patients whose circumstances may make them vulnerable for example, those who may be homeless or those with diagnosed learning disabilities. We were provided with evidence of multidisciplinary team working and case management of vulnerable patients and saw the practice provided drug project worker led clinics each week. Additionally we saw and were given examples of evidence of signposting patients to various support groups and third sector organisations such as Adaction.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Mental Health Services (CAMHS) and adult mental health services. The practice carried out joint patient consultations with local mental health teams where relevant. This helped ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients. The practice recognised patients with mental health needs often required longer than the usual 10 minute appointments and were given as much time as they need. They were regularly reviewed and encouraged to approach the practice if they were concerned about a possible deterioration in their mental health. This open approach was designed to support patients and helped to avert a crisis developing.

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 GP patient survey 2015 and the practices recent monthly friends and family test. 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 GP patient survey showed the practice was rated about average for patients who rated the practice as good or very good. The practice was also about average for its satisfaction scores on consultations with doctors and nurses with 86% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and one letter and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent and accessible service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive, these were about access to appointments. We also spoke with two patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 88% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were in line with other practices in the clinical commissioning group.

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. We saw notices in the practices website informing patents this service was available.

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. For example, 89% of respondents to the National GP Patient survey said the last GP they saw or spoke to was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The

Good

Are services caring?

practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and North Somerset Clinical Commissioning Group (NSCCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, the unemployed, carers and patients experiencing poor mental health. Longer appointment times were available for those patients who needed them.

The practice had access to online and telephone translation services. The practice had a population of mainly English speaking patients though it could cater for other different languages through translation services.

The premises and services had been adapted where possible to meet the needs of patient with disabilities or other needs. An accessible toilet and baby changing facilities were available however, the door to the front entrance had limited width due to a door being locked. There was limited space for storing or parking pushchairs whilst patients waited for appointments. A ramped entrance assisted access into the practice.

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

Access to the service

The practice was open from 8:00 am until 18:30 pm Monday to Friday. Appointments were available from 9:00am to 17:45pm from Wednesday to Friday with the last appointment ending at 17:30pm on Mondays. GP appointments were available from 9:15am to 11:45am on Tuesday mornings supplemented by appointments with the prescribing nurse available between 9:00am and 17:30pm on that day. Nurse appointments were available from 9:00 am to 17:30 pm on Monday and Tuesday mornings and from 9:10 am to 16:30 pm on Wednesday to Friday.

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 patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who lived in three nursing homes, 20 local care homes, four homes for patients with a learning disability and five homes to support patients with a mental health illness, these were carried out by a named GP. Home visits were also available to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP 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.

We observed and spoke with patients in the waiting area of the practice. The two patients we spoke with were complementary about the service they received. However one patient we spoke with had been waiting for over an hour for their appointment. They had not been advised by staff that the GP was running late until approaching the receptionist to ask about the delay themselves. The patient told us this type of delay was unusual but felt they should have been informed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. For example, the complaints procedure was available on the practices website and invited patients to ask for more information at the practice reception desk.

We read two complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way. We noted that details of the actions taken were not recorded on the complaints action log. We also noted, records were not kept where informal or verbal complaints were received and managed immediately by staff.

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 vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice vision and values included; providing a high standard of medical care; continuously improving the health status of the practice population; treating patients and staff with dignity, respect and honesty and ensuring a safe and effective services and environment.

The members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We read six of these policies and procedures. All six policies and procedures we looked at had been reviewed and were up to date according to the timescales indicated for reviewing.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, very 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 discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The nurses we spoke with told us they routinely checked QOF data in the practice to identify areas where patients needed additional appointments or support.

The practice had a programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Aspects of practice they audited included, patient referral figures, gestational diabetes and the resuscitation status of patients in nursing homes. We saw patients were followed up where recall appointments or reviews were required and up to three cycles of audit had been completed.

We were told governance meetings were held on a weekly basis to analyse and discuss the wealth of information they gathered to help improve the services offered. Aspects of the practices governance were effective for example, managing Quality and Outcomes framework information. However other aspects were less robust for example, medicines security and risk assessing emergency medicines and equipment in reflection of current guidance. Routine verbal consent was not recorded from patients for joint injections. Access through the front entrance to the practice had not been responded to in a timely way when highlighted by the patient participation group. Whilst these appeared to be having a minimal impact on patients there was a risk they could begin to affect patient care.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings or informally. Staff also told us the size of the practice and the relatively small staff team meant they met informally several times of the day and were constantly sharing information. They told us they had access to training if needed or requested and we saw GPs regularly attended local learning events. Non-clinical staff told us the partners were always accessible and open to ideas and suggestions.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. We were shown the electronic files that were available to all staff on the practices computer system. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment and suggestions from the website and from the 'Friends and Family' questionnaire. We looked at the results of the annual patient survey and 90% of patients could access appointments easily.

The practice had a patient participation group (PPG) which was actively being recruited to via the practices website. The PPG included representatives from various population

Are services well-led?

Good

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

groups for example, the recently retired, older patients and those with long term conditions. The PPG had carried out surveys and met approximately every month with the partners and practice manager.

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. One member of staff told us that they had asked for specific training around phlebotomy and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We read five staff files and saw that appraisals had taken place which included a personal development plan. However, the appraisals seen were carried out over a year ago. The staff we spoke with confirmed this. The practice manager told us some appraisals were overdue and these were being prioritised for the coming months.

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 **The registered person must ensure the proper and safe management of medicines particularly in relation to its storage and supply of emergency medicines and equipment.** **We found evidence of a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 12(2)(g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities)** **Regulations 2014).**