Seymour Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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

Seymour Medical Centre in situated in the inner city area of Bristol with approximately 12600 registered patients. We undertook a comprehensive announced inspection on 9 December 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector, a practice nurse specialist advisor, an expert by experience and GP specialist advisor.

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

The overall rating for Seymour Medical Practice is good. Our key findings were as follows:

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

We saw several areas of outstanding practice including:

Summary of findings

- Seymour Medical Centre was proactive with future planning and development of services for patients. For example they had introduced a new access project to improve access to medical consultations for patients through a system of triage by GPs.
- Seymour Medical Practice worked in partnership with the local drug project to offer a shared care programme for patients with substance and alcohol misuse. The practice offered regular open clinics for patients with intravenous drug use to be tested for hepatitis.
- The practice participated in innovative programmes such as the tele dermatology project through which the practice accessed specialist dermatological advice for patients.
- We were told about the diabetes 'drop in' educational programme which can be accessed by any patient. This programme offered additional information and support with specific aspects of living with diabetes such as foot care.
- The practice ensured frail older patients were assessed for their potential risk of falling.
- Each month a surgery for carers was held to address any issues they may have.
- We were told about how the practice held focussed sessions to support patient whose circumstances may make them vulnerable. We saw this had been used for the Roma and the Somali communities to educate patients about immunisations and to give them confidence to use healthcare services.
- Clinicians from the practice had recorded short videos for the practice website which advised patients on minor illnesses.
- Seymour Medical Centre participated in national medical research through the Clinical Research Network programme a recent project was screening patients taking long term aspirin for helicobacter.

However, there was an area of practice where the provider needs to make improvement.

The provider should:

- Ensure that the recruitment process is fully implemented for all staff.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. National patient survey data showed that patients rated the practice higher than the Clinical Commissioning Group average for some aspects of care such as staff listening to them. Feedback from patients about their care and treatment was consistently positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted upon. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted upon suggestions for improvements and changed the way it delivered services in response to feedback from the patient reference group (PPG). The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been

Summary of findings

identified. Patients told us they could get an appointment with a named GP and the new access system meant patients who rang the practice had a GP consultation to assess the most appropriate treatment pathway. 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active patient reference group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people in its population and had a range of enhanced services, for example, the practice ensured the frail older patients were assessed for their potential risk of falling and responded as needed. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All of these patients had a named GP and a structured annual review to check that their health and medicine 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations compared to the national average. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had

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been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. We were told about how the practice held focussed sessions to support patients whose circumstances may make them vulnerable. We saw this had been used for the Roma and the Somali communities to educate patients about immunisations.

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 had carried out annual health checks for people with a learning disability which 90% of these patients had attended. It offered longer appointments for people with a learning disability.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. Patients who had attended A&E where they may have been experiencing poor mental health would be offered a follow up appointment at the discretion of the GP involved.It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training about how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

During the inspection we spoke with eight patients who told us they were very satisfied with the service received. Patients described the practice as providing good care with helpful staff.

We also had 26 patients who completed our comment cards; these showed a high level of satisfaction with all areas of the practice, including very positive comments made about staff being knowledgeable, responsive and considerate, with GPs listening to patients and providing clear explanations of treatment.

Patients told us they experienced staff listened to them and supported them well particularly if they were carers and were looking after relatives who were unwell. We were told that the staff at the practice provide a personalised service and often go out of their way for patients. We were told that patients had received telephone calls from their GP. These offered support and encouragement at difficult times. For example, we heard about the experience of a patient living with depression. Whilst another told us about the support they had received for their relative who was terminally ill. We were told that additional home visits had been made without needing to request them, and how the GP had taken time to attend the funeral of the patient.

We reviewed the results from the national GP Patient Survey for 2014 and found the responses did not confirm the experience we heard from patients. The survey had found the proportion of patients who would recommend their GP surgery was 57% which was below the average for the Clinical Commissioning Group (CCG). This was not reflected in the comment cards which had been completed. The proportion of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP practice they were able to get an appointment was 77% of patients which reflected the CCG average. The percentage of patients rating their experience of making an appointment as good or very good was 95%. However from the comments we received where patients told us that telephone access could be difficult to book an appointment.

The practice had a Patient Reference Group (PRG) that consisted of approximately 13 members. The practice arranged regular meetings with these members to discuss any improvements that could be made to the practice. The practice also conducted a survey each year to obtain current views of the service and ask about the specific areas of interest for the practice and the PRG. The focus of the survey was agreed with the PRG and the results were reported back to them. The survey response results for 2013-14 were:-

- 25% of patients find it very easy or fairly easy to get through on the phone which was a reduction on 29% in 2012-13.
- 78% with an urgent healthcare need were able to speak to a GP within two days. In 2012-13 the response was 67% in 2012-13
- 64% could arrange routine appointments with a GP or nurse within two days which was a reduction from 81% in 2012-13.
- 89% used automated check-in which was an increase from 81% in 2012-13.
- 5% had watched the practice's self-care videos

The survey was also available for completion online all year round and the results were collated and included in the annual Patient Reference Report. We saw information from these surveys was used to plan improvements within the practice such as the electronic check in system.

We spoke with two representatives who attended the group. They told us the regular meetings at the practice were really valuable and were attended by a GP and the practice manager. We were told the practice had listened to the group and took their views into account when making decisions about the practice. The practice reported to the group about the action they had taken to address performance as identified in the survey results. For example, the group were consulted about the new GP triage system for accessing consultations and appointments which was introduced to the practice on 1 November 2014.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Ensure that the recruitment process is fully implemented for all staff.

Outstanding practice

- Seymour Medical Centre was proactive with future planning and development of services for patients. For example they had introduced a new access project to improve access to medical consultations for patients through a system of triage by GPs.
- Seymour Medical Practice worked in partnership with a local drug rehabilitation project to offer a shared care programme for patients with substance and alcohol misuse. The practice offered regular open clinics to facilitate patients who use intravenous drugs to be tested for hepatitis.
- The practice participated in innovative programmes such as the tele dermatology project through which the practice accessed specialist dermatological advice for patients.
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- Each month a surgery for carers is held to address any issues they may have.
- We were told about how the practice held focussed sessions to support patients whose circumstances may make them vulnerable. We saw this had been used for the Roma and the Somali communities to educate patients about immunisations and to give them confidence to use healthcare services.
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- Seymour Medical Centre participated in national medical research through the Clinical Research Network programme a recent project was screening patients on long term aspirin for helicobacter.

Seymour Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Seymour Medical Practice

The Seymour Medical Practice is located within the Charlotte Keel Health Centre at Seymour Road Easton Bristol BS5 0UA. The practice is part of the Bristol Clinical Commissioning Group and is situated in the inner city area of Bristol.

The practice shares the Charlotte Keel Health Centre facilities with another GP practice, a community dental service and community health services. Facilities include consulting rooms, a phlebotomy room (for carrying out blood tests) a shared reception and waiting area. The nurse treatment room facilities are shared with the other GP practice. There is level access into the practice and to all patient areas. Toilets are accessible with separate facilities for patients with disabilities and a separate baby changing area. Parking is available on site and close to the practice. There are a range of administrative and staff areas including a meeting area on the first floor of the building. There is lift access to the first floor. The practice is a registered GP training location.

Seymour Medical Practice has approximately 12600 patients registered with a range of cultures and ethnicity. The breakdown of patients age at the practice is:

0-16 years old 21%

16-65 years old 66%

65-74 years old 9%

75 + years old 4%

The practice is in an area of high deprivation with Income Deprivation Affecting Children (IDAC) at 48.0% over twice the national average, and a high level of child emergency admissions for asthma, diabetes and epilepsy. The patient demographic shows high number of younger adults on the patient list with high levels of unemployment and poverty. Living in relative poverty means that families tend to make lifestyle choices that are less healthy than those made by more affluent families. This is indicated by the number of patients with long term conditions. The practice provides additional services planned to meet the specific health issues of the patient group such as those related to smoking, diabetes, obesity, and chronic obstructive pulmonary disease.

There are a number of different ethnicities and languages within the population of the practice. For example, 15% of patients have a South Asian ethnicity, 10% have a Black African ethnicity and 9% are of Afro Caribbean descent. There is an interpreter service onsite to assist with any translation issues and the practice can access Big Word for telephone translation services. 57.81 % of patients come from a Black Minority Ethnic background.

The practice is made up of six GP partners and one nurse partner with six salaried GP's of both genders working alongside nurse practitioners, qualified nurses and health care assistants (all female).

The Seymour Medical Practice is accessible by telephone throughout the day from Monday to Friday from 8.00am to 6.30pm. Appointments may be made by telephone, by calling at the practice or online. Telephone triage requests are taken throughout the day from 8am to 6.30pm to allow GPs to assess urgent requests for care and deal with them

appropriately. Urgent practice nurse appointments or telephone consultations are available on request. Planned routine appointments are released a week in advance for GPs and a month in advance for Practice Nurses. The practice has an extended hours contract which means they offer appointments with nurses and GPs every Wednesday evening from 6.30pm to 8pm and alternate Saturday mornings from 9am to 12.30pm. These appointments are only bookable in advance; there are no urgent appointments at these times. The Practice Nurses offer same day appointments or telephone consultations as requested for urgent problems.

The practice does not provide out of hours services to its patients, this is provided through Bris Doc.

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

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

We carried out an announced visit on 9 December 2014 between 8.30am - 5.30pm.

During our visit we spoke with a range of staff, including GPs, nurses, the practice manager and administrative staff.

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

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

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

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

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

The information from the practice showed the patient demographic profile for the population groups was:

Detailed findings

- Vulnerable older patients (over 75s) 4%
- Patients with long term conditions such as hypertension, diabetes or asthma 31%
- Children and young patients (under 16 years) 21%
- Working age population and those recently retired 74%
- Patients in vulnerable circumstances who may have poor access to primary care including those patients with a learning disability or with opiate dependency 1.2%
- Patients experiencing poor mental health including serious mental health issues, dementia and depression 21%

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 observed there was a security guard onsite who responded to patients who were challenging to staff within the centre. The practice staff, in partnership with health centre staff had effective approaches in handling and diffusing these types of incidents. We reviewed safety records, incident reports and minutes of meetings where these events were discussed for the last 12 months. We were told these occurrences were also discussed during staff appraisal. Documents showed the practice had managed these events and incidents consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review a sample of them. Significant events are reviewed at a monthly meeting and any actions are again reviewed after three months. Staff used the template on the practice intranet to complete a form and these are collated by the Nurse Partner. We tracked five incidents and saw records were completed comprehensively. We reviewed one significant event which related to a new GP registrar's ability to access test results from the Integrated Clinical Environment (ICE) from the University Hospitals Bristol NHS Foundation Trust. We saw this had been raised directly with the Trust but the issue remained an open incident. We asked for and received from the provider reassurance that all tests requested had been carried out and the practice had received a test result. The provider also took further action to follow up the incident with the Trust and alert colleagues through the Clinical Commissioning Group of the potential risk to patient safety.

One GP took responsibility for responding to complaints and concerns. We saw evidence of action taken as a result, for example, one patient had raised a concern about the length of time they had waited for their appointment. We saw the patient concern was acknowledged and they were informed of the actions taken.

National patient safety alerts were disseminated by the partners to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. We were told how the practice had responded to the NHS England alert in relation to Ebola. The practice had held a meeting with all staff to ensure they understood their role and the processes the practice had in place to identify and respond to any potential cases. Staff we spoke with told us this had increased their knowledge about the issue and the action they needed to take.

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 about 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.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level 3 in child protection and could demonstrate they had the necessary experience and understanding to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were' looked after' or on 'child protection plans' were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Good

Are services safe?

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Nursing staff were available to act as a chaperone, if there was no one available then the appointment would be rescheduled. We found there had been limited training for nurses to act in this role which had consisted of the nurses being aware of the policy.

Medicines management

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

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing for sore throats and urinary tract infection were reviewed to ensure the prescribing guidelines were followed within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their roles 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 as these were tracked through the practice and kept securely at all times.

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 professional for infection control who had good understanding of the subject which enabled them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and annual updates. We saw evidence that the lead professional had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. The practice had effective contingency plans for place for sudden staff absence in the nursing team-bank staff were asked to work if required.

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. 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.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and

displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment for example weighing scales, spirometers and blood pressure monitors.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at records relating to the recruitment of GPs and nurses. We found evidence that appropriate recruitment checks for nurses had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS). However the records for GP staff did not contain the same level of evidence, for example we saw that references for GPs had not always been taken and this was contrary to the provider's policy for recruitment.

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 sufficient to meet patient needs.

Monitoring safety and responding to risk

The practice was located in a purpose built environment which it leased and shared with three tenants. The maintenance of the actual building and external grounds was managed by the landlord. The landlord had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We were shown the systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager showed us the recent procedure implemented for the safety and protection of staff against Ebola.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (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. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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 anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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 to whom the staff could refer. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The policy covered joint arrangements with the other practice in the health centre. Records showed 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 GPs and nurse practitioners had access to local, national and international online resources which allowed them to use evidence-based treatment options to care for patients. They were aware of the Clinical Commissioning Group's (CCG) integrated care pathways and collaborated with neighbouring practices through the CCG links to enhance such systems, services and pathways. 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. For example, we were shown how the practice had responded to NICE guidelines about the diagnosis and treatment of hypertension. NICE recommend that a primary diagnosis of hypertension should be confirmed using 24 hour Ambulatory Blood Pressure Monitoring (ABPM). The aim of this was to increase the accurate diagnosis of hypertension, increase the number of people accessing appropriate treatment for hypertension and to contribute to reducing premature ill health and death in the UK. The practice had already used ABPM effectively and in response to the guidance had purchased a second monitor.

GPs and Practice Nurses specialised in clinical areas such as diabetes, heart disease and asthma and there iwas a lead in each area. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of diabetes.

There were processes for making referrals to specialist or investigative services. Routine referrals are completed within a 7 day window. All referrals are now peer reviewed at the Bristol Referral Support service.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were referred on need and age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us 14 clinical audits that had been undertaken in the last year. They were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit to confirm that the GPs who undertook minor surgical procedures were doing in accord with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF which is a national performance measurement tool). For example, we saw an audit regarding whether NICE guidelines were followed when prescribing medicines for patients with diabetes. As a result of the audit, practice nurses took into account the NICE recommendations when prescribing insulin. Nurses and GPs maintained records showing how they had evaluated the patients and documented the success of any changes. The team was also making use of clinical audit tools, clinical supervision and staff meetings to assess the effectiveness of treatments. For example, the practice also used the data collected for the QOF against national screening programme performance rates to monitor their performance and outcomes for patients. Additionally, we saw the practice performance for infant (up to 12 months) immunisations was 100% which was higher than the Clinical Commissioning Group and national average. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement which included all areas of operation.

There was a protocol for repeat prescribing which was in line with national guidance. To ensure compliance the practice had input from a pharmacist who checked that

patients received repeat prescriptions appropriately. For example, the patient had been subject to a medicines review by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, had recorded 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 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. For example we read the results from the Bristol Clinical Commissioning Group End of Life Care Audit 2013-2014 which assessed the Palliative Care list size in respect of several different key areas. The aim was to get an increase of 0.25% of the list size over a six month period and to increase the variety of conditions and recording of advanced care planning discussions with patients. We saw the practice had increased their list by nine patients following the audit.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with a number having additional diplomas in specialist areas of medicine. 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. (This is the assurance on which NHS England bases a recommendation every 5 years to the General Medical Council (GMC) that the GP should continue to hold a Licence to Practice, is a process which is called revalidation. When this has been confirmed by GMC Council can the GP continue to practise and remain on the NHS England performers list).

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 nurses told us they had been supported by the practice to become nurse practitioners. As the practice was a training practice, GPs who were training to be qualified as GPs had longer appointments scheduled with patients. They also had access to a senior GP throughout the day for support. We received positive feedback from the trainees with whom we spoke.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. When there were issues with the system we saw these were reported as significant events and followed up appropriately.

The practice held multidisciplinary team meetings at a frequency dependent on need; for example, we found there were monthly meetings with health visitors to discuss 'at risk' children. We were also told about the close working with attached health care professionals such as midwives, which support the well being of patients through good communication. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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 which enabled patient data to be shared in a secure and timely way. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system.

Good

Are services effective?

(for example, treatment is effective)

(The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained to use 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 spoke with members of the link worker translation service located in the health centre. They told us and we saw how the practice worked closely with interpreters based in the health centre and shared basic patient information with these staff. The interpreters provided information to the GPs which enabled clear identification of patient symptoms and assisted in the diagnosis and treatment of patients. Where the interpreters assisted during clinics a similar two way information exchange took place.

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 them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in writing. The 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. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed.

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 such as the incidence of diagnosed Tuberculosis (TB) which was recorded as 2% of the patients at the practice which was significantly worse than national average figures. This was linked to changes in the Bristol population demographics due to a higher number of patients moving into the area from countries where TB was more prevalent.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. The practice also worked with community health providers to offer ad hoc health checks for adults at community events, the results were sent directly to the patient's GP. 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, all were offered an annual physical health check and this was taken up by 90% of patients. The

Good

Are services effective?

(for example, treatment is effective)

practice data from NHS England showed prevalence of smoking and obesity in the practice population to be higher than the national average. The practice had recorded the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Patients were offered support for their obesity according to their needs as the nurses carried out an initial assessment and advised a management plan for weight loss. Referral for further support with a community health trainer at the local leisure centre was also possible.

The practice offered screening for cervical cancer. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients annually to find those who did not attend. There was a named nurse 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 above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey and a survey of 2% of patients undertaken by the practice's patient reference group (PPG) .The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the practice patient survey gave clear results as measured against the target the practice was striving to achieve. For example, in response to the question 'If you need to consult a GP urgently, are you able to speak to a GP within two days? 78% of patients said yes which was measured against the target of 80% and the rating of 2012-13 which was 67%. The practice was above average in the national patient survey where 88% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments, the local clinical commissioning group average was 84**%**.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. The less positive comments had a common theme of poor access through the telephone system. This was also raised by the PPG who were involved in the 'Access' project to improve this area of performance. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 observed consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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. 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 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 74% of practice respondents said the GP involved them in care decisions. 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 in these areas 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 reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

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 patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, we were told how a patient had received continued telephone support when they suffered a mental health illness. Staff told us that if families had experienced 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. Patients we spoke with who had experienced a bereavement told us they had been supported by the practice, and that the GP had attended the funeral of their relative.

Notices in the patient waiting room, on the patient call boards and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various options of support available to them. the practice also hosted a monthly carers meeting to facilitate access to the surgery and other supportive services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, we read the response to appointments for childhood immunisations was poor from patients with the Roma and Somali communities, so the practice worked with these patients and community workers to arrange special clinics for them so they could all attend as a group.

The practice had used innovative solutions to improve access to secondary treatment. We were told about a teledermatology pilot which facilitated the practice GP to use technology to access a virtual consultant dermatologist consultation. We were told this had been successful for some patients who had an earlier diagnosis and treatment plan.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PPG). For example, in response to the issues of poor telephone access the practice increased the online appointment booking facility.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, services for asylum seekers, those with a learning disability or travellers, unemployed, carers and those patients whose first language was not English. The practice had access to, online and telephone translation services and GPs who spoke more than one language.

The practice provided equality and diversity training through e-learning for all staff. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. The most effective ways of working with local ethnic groups and vulnerable patients was discussed at staff meetings and team events.

The premises and services had been designed to meet the needs of patients with disabilities. There was level access into the practice and parking spaces for patients who were disabled. All GP and nurse consulting rooms were on the ground floor, where access was needed to the first floor meeting room or practice managers office, a lift was available. The practice had wide corridors to enable access for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, facilities included baby changing facilities.

The practice provided services for patients whose circumstances made them vulnerable. The practice kept a register of patients they were aware of who lived in vulnerable circumstances and had a system for flagging vulnerability in individual records. Patients were able to register with the practice irrespective of their circumstances, including those with "no fixed abode". Patients not registered with the practice were able to access appointments by speaking with reception staff who arranged for them to see the next available GP or nurse. We also heard about the 'drop in' clinic for hepatitis testing for patients who were intravenous drug users. Patients attending this clinic did not need an appointment and could be tested and treated confidentially.

Access to the service

The Seymour Medical Practice was accessible by telephone throughout the day from Monday to Friday from 8.00am to 6.30pm. Appointments could be made by telephone, by calling at the practice or online. Telephone triage requests are taken throughout the day from 8am to 6.30pm to allow GPs to assess urgent requests for care and deal with them appropriately. Urgent practice nurse appointments or telephone consultations are available on request. Planned routine appointments are released a week in advance for GPs and a month in advance for Practice Nurses. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice had an extended hours contract which meant they offer appointments with nurses and GPs every Wednesday evening from 6.30pm to 8pm and alternate Saturday mornings from 9am to 12.30pm. These appointments were only bookable in advance; there were no urgent appointments at these times. Practice nurses offer same day appointments or telephone consultations as requested for urgent problems.

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 about 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 as appropriate when requested.

Patients we spoke with were generally satisfied with the appointments system. The practice had introduced a new appointment access system from 1 November 2014. This system allowed patients to telephone the practice as usual and their request would be passed to a GP who would contact them within an agreed time frame to assess them. We were told the value of this system was that every patient who contacted the practice had a medical consultation with a GP who decided on the most appropriate course of action. The system also provided a greater continuity of care as patients were contacted by their GP wherever possible. The system was also introduced to target resources and reduce the number of 'did not attend' which for November was approximately 600 appointments. The data collected by the practice to date indicated that 55% of consultations did not require a face to face appointment. The statistics also indicated that on some days there were 'unused' appointments. Patients confirmed that they could see a GP on the same day if they needed to and 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.

The practice promoted patients to be self caring and take charge of their health. To facilitate this and also to reduce demand for appointments the partners had recorded self help videos for their website to guide patients who may have minor illness to the most appropriate service.

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 process and we saw all comments and complaints were recorded with an outcome for the complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found they had been responded to within the timescale, with a written explanation to the patients of the findings of the practice investigation.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and saw a theme relating to appointment waiting times had been identified. The practice manager was able to tell us the actions taken in respect of this issue, which showed how lessons learned from individual complaints had been acted upon.

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 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. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included a statement to provide the highest standard of medical care possible for all patients, to consider the patient as a whole, set in the context of their lives and culture. We spoke with a range of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at five policies and procedures and saw the policies and procedures we looked at had been reviewed annually and were up to date. We saw staff were introduced to the policies through their induction and that changes were highlighted through the team meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The 2012-13 QOF performance for the practice showed it had achieved 98.6% which was higher than the clinical commissioning group average.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. In addition, we saw the 'Medicines Optimisation Pharmacist' employed by the clinical commissioning group, worked with the practice and reviewed prescribing so that medicines were prescribed therapeutically. The practice also participated in national patient research programmes on a variety of subject. We were told a forthcoming project was assessing the efficacy of specific creams for babies.

The practice had robust arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example the practice reassessed their infection control policy and procedures in respect of the risk presented by patients returning from Africa with the symptoms of Ebola. The practice held regular governance meetings. We looked at minutes from the meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We looked at minutes from staff meetings and saw information presented in a way to inform and educate staff. We were told by staff they found these meetings were useful and they could access any they had missed to catch up on what had been discussed.

There was a clear leadership structure with named members of staff in lead roles called committees. For example, there was a lead nurse for infection control and each partner took the lead for a specific area of operation. The practice had a senior management meeting where each committee fed back information about practice performance which gave a clear process for decision making. The staff we spoke with were all clear about their own roles, responsibilities and accountabilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice manager was responsible for human resource policies and procedures. We were told about the information for staff that was available on the intranet, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had an active patient reference group who had carried out surveys and met every quarter. We looked at the minutes and saw waiting room noise had been raised as an issue. The minutes from the review meeting

Are services well-led?

Good

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

between the PPG and the practice recorded that the actions in this area designed to tackle waiting room noise and improve ways of navigating to the right place in the health centre. These actions were improved patient signage and the broadcasting of messages on the patient call boards. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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 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 in the staff handbook and electronically via any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisal took place which included a personal development plan. Staff told us the practice was very supportive of training and that they had guest speakers and trainers who facilitated training sessions.