

Birbeck Medical Group

Quality Report

Penrith Health Centre
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Birbeck Medical Group on 12 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the following population groups: 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).

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice had developed comprehensive care plans which included relevant socio-economic details as well as medical information.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

Summary of findings

- 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.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- 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.

We saw one area of outstanding practice:

- The practice held weekly learning disability clinics and patients attending these clinics were encouraged to contribute to their own action plan which they were then given to keep and refer to.

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

- Ensure there is a standard process in operation regarding the monitoring and recording of drugs held in GP bags.

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 with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There were enough appropriately trained staff on duty at all times to keep patients safe and the practice was clean and hygienic. All clinical staff had been checked with the Disclosure and Barring Service (DBS). Administrative staff had not been DBS checked but risk assessments were in place outlining why this was not considered to be necessary.

Are services effective?

Good



The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were in line with other practices in the local Clinical Commissioning Group (CCG) and nationally. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice had systems in place for completing clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and all staff had received training appropriate to their roles and responsibilities. Staff received yearly appraisals which gave them the opportunity to formally discuss personal and performance issues and identify training and development needs.

Are services caring?

Good



The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were better than the national average. Patients said they were treated well and were involved in making decisions about their care and treatment. Patients had access to information and advice on health

Summary of findings

promotion, and they received support to manage their own health and wellbeing. Staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback about the practice was good and most stated they found it was easy to make an appointment with a GP within an acceptable timescale. The practice had good facilities and was well equipped to treat patients and meet their needs. Easy to understand information about how to complain was available and evidence showed the practice responded quickly and appropriately to issues raised.

Good



Are services well-led?

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients, which they acted upon. An active patient participation group (PPG) was in existence and met regularly. Comprehensive induction guidance was available for staff. Regular staff meetings were held and staff received yearly appraisals.

Good



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 patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 had a named GP and home visits were offered to elderly patients who were unable to visit the surgery. GPs attending home visits were equipped with care plans, where appropriate and a printout of the patients relevant medical history which was then be made available to ambulance and hospital staff should that patient require admission. Over 75 years of age health checks were not routinely offered but the practice was participating in a scheme where patients of 83 years of age and above had been asked to complete a health questionnaire and offered a health check if felt necessary based on the information provided.

Regularly reviewed care plans had been introduced for the practice population who had complex health needs and were most at risk of unplanned hospital admission. These patients were recorded on the practices unplanned admissions register and computer system to ensure staff were aware of and able to deal appropriately with their needs.

Nursing and residential homes in the practice vicinity were allocated two to three named GPs dependent on size to ensure continuity of care for patients with complex needs, many of whom had a regularly reviewed care plan. Home visit requests for residents were automatically agreed without the need for triage.

The practice were also in the process of appointing a part time 'community' GP for an initial trial period of six weeks commencing June 2015. This GP would be responsible for the care of patients who were mainly housebound and, potentially, palliative care patients and those requiring cancer reviews. If the pilot proved to be successful the practice hoped to be able to secure the funding to continue with the scheme.

Clinicians collect patients from the practice waiting room which enables them to assess patients' mobility and other issues prior to consultation. This also aids patients with visual and hearing impairments. Clinical staff also routinely scheduled in appointment time for telephone consultations or discussions with patients' carers.

Summary of findings

The percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average at 76.4% (national average 73.2%). The practice also actively identified and supported palliative care patients.

People with long term conditions

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

The practice was able to demonstrate effective, comprehensive and regularly reviewed care planning for patients with long term or complex conditions and had a system in place to ensure patients were recalled for reviews when required. Chronic disease management clinics were held to cover a wide variety of diseases and the practice was in the process of reviewing the way in which these clinics were delivered to ensure that patients with multiple chronic diseases need only attend one review clinic. Nursing staff were encouraged to seek and given time to attend continuous professional development training courses in the treatment of such diseases.

The practice had identified their patients most at risk of an unplanned hospital admission and had sent a letter to all of these patients notifying them of their named GP and care co-ordinator as well as inviting them to cooperate in the development of a fully comprehensive personal care plan.

The practice had a very effective and well developed diabetic care team involving two of the GPs and three of the practice nurses, all of whom had Certificates in either Diabetes Control or Optimising Glycaemic Control from Warwick University. The team was providing care for 861 of the practices' population. This included six monthly reviews (to be increased to yearly reviews for those patients with good control of their condition), easy access (including open telephone access) for patients commencing insulin injections, an attached dietician and podiatrist and strong links with Diabetes UK. The team had also been involved in local initiatives including the standardising of blood glucose sampling (BM) machines. The Nurse Manager had worked with the local leisure centre to encourage diabetic patients to exercise by establishing a course of private swimming sessions at a reduced cost. The processes in place had ensured that the practice had a high uptake in encouraging diabetes patients to educate themselves about and self manage their condition in line with DESMOND protocols. DESMOND is a training programme aimed at encouraging diabetes education and self-management for newly diagnosed patients.

Good



Summary of findings

The practice had a system in place to ensure that patients discharged from hospital were contacted to review their medication and ensure the patients' needs were being met.

Families, children and young people

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 looked after children or children subject of a child protection plan. The practice held monthly meetings with health visitors, school nurses, midwives and A&E staff to discuss safeguarding concerns and other issues of concern such as high levels of school non-attendance. Immunisation rates were in line with or slightly below local averages for all standard childhood immunisations. For example, meningitis c vaccination rates for 12 month old children were 85.3% compared to 82.5% locally; for two year old children 96.6% compared to 97.6% locally; and for five year old children 93.9% as compared to 96.6% locally. Appointments were available outside of school hours and up to 8.30pm two nights per week. Cervical screening rates for women aged 25-64 were above the national average at 83.2% (national average 81.9%) and sexual health clinics were available several times per week. A substance misuse practitioner attended the practice one day per week and patients were able to self-refer to this service as well as being referred by their GP.

Good



Working age people (including those recently retired and students)

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

Nationally reported data showed that 57.9% of the practice population either worked or was in full time education. The practice was proactive in meeting the needs of these patients by offering on-line services such as being able to order repeat prescriptions, book appointments and view immunisation and allergy medical history. The practice offered lunchtime appointments and extended opening hours up to 8.30pm on two nights per week. A text messaging appointment reminder service for patients was also available. Repeat prescriptions could be ordered at any time either online or by phone and prescriptions could be sent electronically to a nominated pharmacy. The practice were also involved in the Choose and Book scheme which enables patients referred to a hospital or clinic to choose the provider of their choice and at date and time which is convenient.

Good



Summary of findings

People whose circumstances may make them vulnerable

Good



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

The practice had a register of patients aged 18 or over with a learning disability and had a recall system in place to ensure these patients were offered an annual health check. Weekly learning disability clinics were held and patients attending these clinics contributed to their own action plan which they were then given to keep and refer to.

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified clinical and non-clinical lead staff for dealing with vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role. Multi-disciplinary safeguarding meetings were held on a monthly basis. This included a Substance Misuse Practitioner who also attended the practice one day per week and saw patients who had either been referred by a practice GP or who had self-referred. An information sharing agreement was in place and patients' written consent was obtained to enable the practitioner to be able to view and record notes on patients medical records.

The practice was proactive in identifying carers. Carers were routinely offered an annual health check as well as the offer of a referral to the local carers centre.

Palliative care patients were allocated two named GP's and given direct access to the medicines management lead to facilitate a timely response to an urgent prescription requests.

Multi-disciplinary palliative care meetings were held on a regular basis.

People experiencing poor mental health (including people with dementia)

Good



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

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (89.5% compared to a national average of 86%).

A practice nurse had been identified as the lead for patients with mental health issues, including dementia and attended weekly

Summary of findings

meetings with the local mental health team and memory service. Practice staff had attended dementia awareness training and are 'Dementia Friends' (Dementia Friends is an initiative to help people with dementia feel understood and included in their community).

The practice was able to demonstrate effective working relationships with the Community Mental Health Team, Community Psychiatric Nurses and Substance Misuse workers and provided consultation rooms for these services. The practice also worked closely with Cumbria Partnership Foundation Trust to ensure the health needs of patients with eating disorders were met.

Summary of findings

What people who use the service say

During the inspection we spoke with five patients, reviewed 22 Care Quality Commission (CQC) comment cards completed by patients and a letter from a patient addressed to the CQC which we were given at the start of our inspection. The feedback we received indicated the majority of patients were very happy with the care and treatment they received, felt they were treated with dignity and respect and received a service which met their needs.

Findings from the 2014 National GP Patient Survey published in January 2015 for the practice indicated most patients had a good level of satisfaction with the care and treatment they received. The results were generally in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. For example:

- 91% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. National average 82%
- 93% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. National average 85%
- 92% of respondents said the last nurse they saw was good at treating them with care and concern. National average 91%

These results were based on 120 surveys that were returned from a total of 265 that were sent out (response rate of 45%)

Areas for improvement

Action the service **MUST** take to improve

Action the service **SHOULD** take to improve

- Ensure there is a standard process in operation regarding the monitoring and recording of drugs held in GP bags

Outstanding practice

We saw one area of outstanding practice:

- The practice held weekly learning disability clinics and patients attending these clinics were encouraged to contribute to their own action plan which they were then given to keep and refer to.

Birbeck Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team also included a second CQC Inspector, a GP and a specialist advisor with experience of practice management

Background to Birbeck Medical Group

The practice is based within Penrith Health Centre and provides care and treatment to 15,823 patients within a 10 mile square radius of Penrith. Of those 15,823 patients, 12,246 are under the age of 65, 1,900 are between the ages of 65 – 74 and 1,677 are over the age of 75. The practice is part of the Cumbria Clinical Commissioning Group (CCG).

The practice provides services from the following address, which we visited during this inspection:

Birbeck Medical Group, Penrith Health Centre, Bridge Lane, Penrith, Cumbria, CA11 8HW

The practice is open between 8am to 6.30pm on a Monday, Tuesday and Friday and between 8am and 8.30pm on a Wednesday and Thursday. The first appointment is 30 minutes after surgery opening time and the last appointment is 30 minutes before surgery closing time.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Cumbria Health on Call (CHoC).

Birbeck Medical Group offers a range of services and clinic appointments including chronic disease management clinics for patients with diabetes, kidney disease and heart

and respiratory conditions as well as family planning, cervical screening, NHS health checks, immunisations, vaccinations and foreign travel advice. The practice consists of seven GP partners and four salaried GPs (seven male and four female). There are also two nurse practitioners, eight practice nurses, two healthcare assistants and 28 support staff. The practice is a teaching and training practice and provides training for medical students and GP trainees.

The practice supports the BEEP fund (Birbeck Emergency Equipment for Patients) which is an initiative set up by one of the GP's to provide equipment and training for the care of casualties involved in accidents and emergencies in the surrounding area. Another of the GPs was a member of the mountain rescue team.

The Care Quality Commission (CQC) intelligent monitoring tool placed the area in which the practice is located in the eighth (out of ten) most deprived decile. In general people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile showed higher percentages of patients aged over 50 than the national average.

Why we carried out this inspection

We inspected this service as part of our 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 registered provider is

Detailed findings

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 Care Quality Commission (CQC) at that time.

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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 May 2015. During our visit we spoke with a range of staff including four GPs; the practice manager; practice nurses; a healthcare assistant and members of the management, administration and reception teams. We spoke to five patients, one of whom was a member of the practice patient participation group (PPG) and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 22 Care Quality Commission (CQC) comment cards that had been completed by patients and a sealed letter from a patient addressed to the CQC which we were given at the start of our inspection. We also looked at the records the practice maintained in relation to the provision of services.

Are services safe?

Our findings

Safe track record

As part of planning our inspection we looked at a range of information available about the practice including information from the latest GP Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. For example, reported incidents, 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 accidents and near misses. For example an incident had been recorded where test results for a patient had been recorded on her husband's medical record in error. This error had been identified when the patient had rang the practice for the test results. This was discussed at a practice meeting and as a result a new protocol had been introduced where patients handing in samples were asked to complete the label on the sample container and accompanying form themselves to avoid confusion and errors.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded 22 significant events/incidents during the period 1 April 2014 to 31 March 2015 covering a wide range of issues. We would expect to see this number of significant events in a good practice of this size as it demonstrates an open and transparent culture and a willingness to learn from mistakes. The practice was able to demonstrate the action taken to ensure these issues did not happen again and also how information

regarding such incidents was disseminated to staff by way of monthly minuted meetings. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

The practice manager was responsible for cascading national patient safety alerts to relevant clinical staff and medicines management leads. Audits of patients who had been prescribed, for example, a particular medication would be undertaken and affected patients informed or recalled for a medication review if required. We saw evidence that where a patient had a care plan in place, and the practice identified a change in medication; the care plan was also changed to take account of this.

Reliable safety systems and processes including safeguarding

The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. Clinical and non-clinical members of staff had been identified as the leads for safeguarding vulnerable children and adults and effective working relationships had been established with multi agency practitioners. For example, monthly multi-disciplinary meetings were held involving the GP, practice nurse, administration safeguarding lead, midwives, A&E nurses and substance misuse practitioner to discuss vulnerable children. Staff told us that the aim of these meetings was not only to discuss children already subject of child protection plans but also to target early intervention at children or families where concerns had been identified but who had not reached the threshold for child protection intervention. Similar arrangements were in place for vulnerable adults. Staff we interviewed stated they would feel confident in making a safeguarding referral and were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any relevant issues when patients rang to make or attended appointments.

A chaperone policy was in place and information about this was displayed in the practice leaflet and on the doors leading to the clinical rooms. All nursing staff, including the

Are services safe?

health care assistants, had been trained to be a chaperone (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) and had also received Disclosure and Barring Service (DBS) check.

Patients' records were kept on an electronic system which stored all relevant medical information. As well as flagging vulnerable children and adults the system also flagged patients with dementia, mental health issues, learning difficulties and those receiving palliative care which helped ensure risks to patients were clearly flagged and reviewed.

Staff were able to easily access the practice's policies and procedures. This helped to ensure that when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines management

Effective arrangements were in place to ensure medicines requiring cold storage such as vaccines were stored appropriately. A policy was in place to ensure fridge temperatures were checked and recorded daily by practice staff. This ensured that medication stored in the fridges was safe to use.

The practice held a register of emergency and other drugs that were held on the premises. These drugs were stored in a locked cabinet with restricted access. During our inspection we found that a process was in place to check these drugs on a monthly basis to ensure they were in date, destroyed and re ordered when required. Drugs that had expired and were waiting to be disposed of by an independent pharmacist were stored within a separate locked box within the locked cabinet to prevent them from being used accidentally. Staff told us that they would also always routinely check the expiry date of any medicine before it was administered.

The GPs who carried drugs in their bags were responsible for also keeping the drugs register for these items. During our inspection one of the registers was found to be inconsistent and not compliant with the relevant regulations. This was because one of the GPs, although recording when drugs were administered, was not recording what drugs had been obtained from the surgery stock nor maintaining a running total. We raised this matter with the practice who accepted the error and the need to reinforce monitoring and recording arrangements currently in place.

The practice staff were aware of the need to monitor the prescribing of controlled drugs and when and how to raise any concerns. This included alerting the out of hour's provision.

The practice manager was responsible for cascading national patient safety alerts to relevant clinical staff and medicines management leads who would then ensure appropriate action was taken. This included medication reviews, contacting affected patients and amending care plans.

Patients were able to re-order repeat prescriptions in a variety of ways including ordering at the practice, by telephone, on-line or by post. Staff were well aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect.

We saw evidence to confirm that the practice recorded medicines incidents and prescribing errors as significant events and ensured that similar errors did not recur. An example of this was when a patient was prescribed Fluoxetine (medication for depression) instead of Flucloxacillin (an antibiotic) which resulted in the practice introducing a double checking system for the signing of prescriptions.

Cleanliness and infection control

The premises were clean and hygienic throughout. None of the patients we spoke with or who completed CQC comment cards had any concerns regarding the level of cleanliness at the practice. A cleaning schedule was in place and supervised audits of cleaning standards were carried out on a monthly basis.

An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. One of the nursing staff was designated as infection control lead and provided advice and guidance to colleagues when needed. Both clinical and non-clinical

Are services safe?

staff had received infection control training. Infection control audits had been completed to ensure staff were following infection control policy and to ensure the policy was effective in the prevention and control of infections.

The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and replaced every six months or more regularly if required.

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms and were appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, hand soap, antibacterial gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice. The practice had a protocol for the management of clinical waste and a contract was in place with Penrith Hospital to ensure safe disposal. All waste bins were visibly clean and in good working order.

The practice was able to demonstrate that a process was in place for the management, testing and investigation of legionella (a bacterium that can grow in water and can be potentially fatal) on a regular basis. The next planned assessment was in January 2017.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. We saw evidence to confirm the equipment was regularly inspected and serviced. This included the practice defibrillator (a device used to restart the heart in an emergency) which was next due to be checked in February 2016 and oxygen equipment which was due to be checked in 2017. Up to date calibration certificates were seen for equipment such as the spirometer (a device that measures the volume of air inspired and expired by the lungs) and weighing scales. All portable electrical equipment was routinely tested and displayed stickers indicating the next test date was due in September 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included seeking proof of identification, references, qualifications, licence to practice if appropriate and Disclosure and Barring (DBS) checks. We viewed staff files

and found this to be the case. We also checked the General Medical (GMC) and Nursing and Midwifery Council's (NMC) records to confirm that all of the clinical staff were licensed to practice. In addition we found that all clinical staff had the necessary medical indemnity insurance. DBS checks had been carried out for all clinical staff. Administrative staff had not received DBS checks but risk assessments were in place indicating why this was not felt to be necessary. This was because this staff group did not carry out chaperone duties or have one to one contact with children or vulnerable adults.

The practice manager told us about the arrangements that were in place for planning and monitoring the number and mix of staff needed to meet patients' needs and to ensure there were enough staff on duty. Administrative staff were split into individual teams and managed by a team leader who would use a colour coded staff rota to ensure there was sufficient cover in that team at all times. At times of extra pressure part time staff were flexible and would temporarily increase their working hours. GPs and nurses discussed and planned their annual leave in conjunction with each other to ensure sufficient clinical cover at all times. The practice did not need to rely heavily on the use of locums but when this was necessary tended to use GPs who were ex partners or employees and already known by the staff and patients. We were shown a comprehensive locum induction file which contained, for example policies and procedures, safeguarding referral information and relevant contact numbers. Staff told us that each locum would be allocated a practice secretary for support during the period of their contract. Staff stated they felt there were enough staff to maintain the smooth running of the practice to keep patients safe.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included regular checks of medicines management, premises, equipment and staffing. The practice had a health and safety policy and staff had received health and safety training. We checked the premises and found it to be safe and hazard free.

Staff told us of the process they would follow if there was a medical emergency on site. The member of staff alerted about the incident would activate an alarm at the reception desk which would alert clinical staff that their immediate attendance was required. Emergency bags and

Are services safe?

equipment were readily available and clear roles identified for the staff in attendance. Staff informed patients in the waiting room of any anticipated delay and the practice business continuity plan was invoked if necessary. This process had been reviewed and strengthened following a major incident in the practice car park in 2013.

Staff gave us an example of how they identified and responded to changing risks to patients including deteriorating health and well-being. This included arranging collaborative multi-agency intervention for a patient whose physical health was clearly being affected by socio-economic factors and taking extra steps to ensure that patients with mental health issues had appropriate care and support if also diagnosed with complex or terminal illnesses.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records confirming that staff had received training in basic life support and cardio-pulmonary resuscitation (CPR).

Emergency equipment was available including resuscitation equipment and a defibrillator. Emergency medicines were stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The practice had carried out a fire risk assessment in October 2014. Fire extinguishers were in date and fire exits clearly signposted.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health Excellence (NICE) guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had introduced a policy regarding the diagnosis, assessment and management of patients with atrial fibrillation (a heart condition causing irregular and often abnormally fast heart rate) and ensured there was an appropriate use of anticoagulant medication for those patients with this condition at low risk of experiencing a stroke. The practice had also taken steps to ensure there were effective protocols in place and monitoring of the prescribing of antibiotics. GPs told us that weekly clinical meetings were held where NICE guidance, specific conditions or cases causing concern were discussed.

Chronic disease management clinics were held to cover a wide variety of diseases and the practice was in the process of reviewing the way in which these clinics were delivered to ensure that patients with multiple chronic diseases need only attend one review clinic. The practice had identified their patients most at risk of an unplanned hospital admission and taken steps to ensure that these patients were notified of their named GP and were involved in developing a fully comprehensive personal care plan.

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

The GP partners monitored how well the practice performed against key clinical performance indicators such as those contained within the QOF (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). Staff across the

practice had key roles in monitoring and improving outcomes for patients and there were designated leads for information governance, safeguarding, palliative care, medicines management and referrals as well as some long term conditions.

The practice was able to demonstrate that it was undertaking clinical audit cycles to help improve patient outcomes. We saw examples of a number of audits including a completed audit cycle in relation to a review of patients prescribed hypnotic medication for insomnia (with the exception of patients experiencing mental health problems). As a result of this audit the prescribing of hypnotics had reduced following the introduction of reduction plans for patients and information on how to cope and deal with sleeping problems without medication. 35 patients had been able to successfully stop taking this medication. Audits had also been completed on the use of certain non-steroidal anti-inflammatory drugs (NSAIDS) to address possible side effects stemming from long term use and on the use of Ezetimibe (a drug used to lower cholesterol).

The practice used the information collected from QOF and performance against national screening programmes to monitor outcomes for patients. For example 89.5% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record in the preceding 12 months which had been agreed with the patient and their family/carers. 95.3% of patients with diabetes had received a foot examination and risk classification within the preceding 12 months. Where QOF performance fell below the national average the practice were proactive in trying to rectify this. For example the percentage of diabetes patients in whom the last blood pressure (measured in the preceding 12 months) was 140/80 mmHg or less was less than the national average at 62.9% (national average 78.6%). As a result the practice were trying to ensure more regular reviews were offered to diabetic patients most in need by reducing reviews for diabetic patients effectively managing their disease to yearly intervals. We confirmed the practice had obtained the maximum number of points available to them for delivering a good standard of care to patients with a range of conditions including chronic obstructive pulmonary disease, dementia, depression, heart failure, hypothyroidism, rheumatoid arthritis, stroke & ischaemic heart failure and to patients with a learning disability or those in need of palliative care.

Are services effective?

(for example, treatment is effective)

Information we looked at prior to our inspection indicated that the practice fell well below both the CCG and national average in relation to the percentage of patients with osteoporosis (a condition that can cause bones to weaken and break) who had suffered a broken bone and were on an appropriate medicine. The GP we spoke to about this stated that it was possible this was due to a coding error (patients who fit into these criteria had not been properly flagged on the practice computer system). The GP also told us that the practice had undertaken a single cycle audit and review of patients on this medication as national guidance had indicated prolonged use was not beneficial and could be harmful. 70 patients had been identified as being on this medicine and following face to face reviews this number had reduced to 35.

Effective systems were in place which helped to ensure patients received prompt care and treatment. For example, all hospital discharge and advisory letters were dealt with effectively and within 48 hours of receipt. This included reviewing medication and the addition of a code onto a patient's record if necessary. An example of this would be the adding of an alert in respect of end of life care to a patient's record.

There was a protocol for repeat prescribing which was in line with national guidance. Staff were aware of the action to take when a patient had reached the authorised number of repeat prescriptions.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of seven GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, fire safety, information governance, security and confidentiality, safeguarding, equality and diversity, customer care, dementia awareness and more clinical based training for clinical staff.

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). Nursing staff reported they were supported in seeking and attending continual professional development and training courses. In addition, the practice had been involved in working with the local University to establish a training programme for student nurses which was due to commence later in 2015. It was envisaged that this would provide extra resources and training opportunities for practice nurses. As a teaching practice the practice was also committed to GP training as well as to the training of F2 doctors (an F2 doctor is a grade of medical practitioner undertaking a two year postgraduate medical training programme to become a specialist or GP) and medical students.

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 and staff training files confirmed this. As the practice was a training practice, doctors who were training to be qualified as GPs were allocated extended appointment times and had access to a senior GP for advice. We received positive feedback from the trainees we spoke with.

We looked at staff cover arrangements and identified that there was always sufficient GP cover on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. Administrative staff covered for each other and part time staff would increase their working hours if necessary to meet demand. When the practice did need to use locum GPs staff told us that these were usually ex GP members of staff or partners who were well known to staff and patients. A very comprehensive locum induction pack was in existence.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

Are services effective?

(for example, treatment is effective)

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held monthly multidisciplinary team meetings to discuss palliative care patients and vulnerable children. The practice was also able to demonstrate effective multi-agency working with local substance misuse, community and mental health teams

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider.

The practice had developed comprehensive personal care plans for patients with complex healthcare conditions which would accompany any GP making a home visit. The care plans would then be immediately available for ambulance or hospital staff should the patient require admission to hospital. These care plans not only contained relevant medical information but had been developed to include other useful information such as socio-economic factors, details of carers, support.

Emergency hospital admission rates for the practice were slightly higher than the national average at 18.3% (national average 13.6%). The practice had a process in place to follow up patients discharged from hospital and for dealing with hospital communications. An audit of the quality of information received by the practice from discharging hospitals was carried out on a yearly basis for follow up by the relevant NHS trust.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (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 and patients welcomed the ability to choose their own appointment dates and times.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage

patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 120 patients who participated in the 2014 National GP Patient Survey published In January 2015, 91% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 82%. The same survey revealed that 85% of patients felt the last nurse they had seen had been good at involving them in decision about their care which was the same as the national average.

Staff told us that they asked patients for their consent before undertaking any care or treatment and acted in accordance with their wishes. Staff told us that they ensured they obtained patients' written, verbal or implied consent to treatments. We saw a copy of the patient consent form used by the practice for some medical treatment, immunisations, investigations and operations. A scanned copy of the signed consent form would be saved on a patient's electronic record.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The patient consent form explained Gillick competency.

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). Staff we spoke with were able to demonstrate an understanding of the Mental Capacity Act 2005 and their responsibilities in relation to this. One of the GPs was able to give an example of how patient's best interests were taken into account if the patient did not have the capacity to make a decision.

Health promotion and prevention

There was a range of information on display within the practice reception area which included a number of health

Are services effective?

(for example, treatment is effective)

promotion and prevention leaflets, for example on asthma, chronic obstructive pulmonary disorder, depression, sexual health, musculoskeletal problems, antibiotic use and immunisations. The practice's website also included links to a range of patient information including family health, long term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff told us this system worked well and prevented any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 at 83.2% was above the national average of 81.9%.

The practice offered NHS health checks for patients between the age of 40 and 74. During the period 1 April 2014 to 31 March 2015 the practice had offered 660 patients a health check and 334 patients had subsequently received one. New patient health checks were offered to patients who indicated they had a chronic disease or were on regular medication.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was in line with averages for the CCG. For example, meningococcal C (Men C) vaccination rates for 12 month old children were 85.3% compared to 82.5% locally; for two year old children 96.6% compared to 97.6%; and for five year old children 93.9% as compared to 96.6% locally. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 58.8% (national average 52.2%).

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with, including a member of the patient participation group said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 22 CQC comment cards completed 19 were positive. Words used to describe the practice and staff included excellent, professional, discrete, supportive, effective, helpful and caring. Some comments received were in relation to having to wait for an appointment to see a named GP. On the day of our inspection staff passed us a letter from a patient addressed to the CQC but sent to the practice for our attention. This was a letter of praise in respect of one of the practice nurses for the level of care and explanations given during treatment.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A system had been introduced to allow only one patient at a time to approach the reception desk to prevent conversations being overheard. A poster displayed in the reception area advised patients that a room was available if they wished to speak to a receptionist in private. The practice had also introduced the playing of low level music in the reception area to further reduce the chance of conversations being overheard.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

Staff were aware of the need to keep records secure. We saw that patient records were computerised and systems

were in place to keep them safe in line with data protection legislation. One of the partners was nominated as a Caldicott Guardian (a person responsible for protecting the confidentiality of a patient and enabling appropriate information sharing).

Care planning and involvement in decisions about care and treatment

The national 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, the survey showed 91% of the 120 patients who responded to the survey said the last GP they saw or spoke to involved them in decisions about their care and 85% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the national averages.

The majority of the survey results for the practice were above the national averages. For example, 91% of respondents described their overall experience at the GP surgery as fairly good or very good compared to the national average of 86%.

The practice sought views from patients both in the surgery and on line as to whether they would recommend the practice to friends and family. 93% of respondents had said they would.

We saw that a translation and interpreter service was available for patients who did not have English as their first language. Providing this type of service helps to promote patients' involvement in decisions about their care and treatment.

A hearing loop had been installed at the reception desk to aid patients with hearing impairments. One of the receptionists had attended deafness awareness training and the practice manager had recently attended a similar training session. The practice did not have electronic screens advising patients when to go to the consultation room as the clinical staff collected patients from the waiting room in person. Clinical staff felt this gave them an additional opportunity to assess a patient's mobility and general presentation prior to consultation and assessment.

Patient/carer support to cope emotionally with care and treatment

Are services caring?

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring, helpful and supportive.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice was proactive in identifying carers who were routinely offered annual health checks and offered a

referral to the local carers support service. New patients registering with the practice were asked if they had caring responsibilities. The practice computer system alerted staff if a patient was a carer. Television screens displaying a variety of information, including information for carers, were located in the reception area.

Patients who had experienced an unplanned admission to hospital were contacted by the medicines management team following discharge to ensure all their needs were being met and to discuss any medication changes.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment. For example, the practice had a palliative care register and held six monthly multidisciplinary meetings to discuss patients and their families' care and support needs. The practice approach to providing end of life care was in line with gold standard framework guidance and the 'Deciding Right' initiative both of which aim to deliver a fully integrated approach to optimising care for palliative care patients. This had led to the development of red, amber, green (RAG) rated care planning and information sharing with other health care professionals.

The practice held a register of those patients with a learning disability or mental health condition. These patients were offered an annual health check. The practice had developed an effective working relationship with the local mental health team and a Community Psychiatric Nurse visited the practice on a weekly basis. Vulnerable patients, for example, patients who were carers were coded on the practice computer system to enable staff to identify them and ensure their needs were met. The practice had taken steps to ensure all dementia patients were identified and all practice staff had attended dementia friends training.

The practice had a higher than national average number of patients over the age of 75 (10.4% compared to the national average of 7.6%) but ensured that all of these patients had a named GP. Nursing and residential homes in the practice vicinity were allocated two or three named GPs dependent on size and home visit request for residents were arranged without being triaged and carried out by one of the named GPs. Other home visit requests were discussed between the GPs and the most appropriate GP would visit. GPs ensured that they attended any home visits equipped with all relevant medical information and, if in existence, care plans to ensure that relevant information was available for ambulance and hospital staff should the patient require admission to hospital.

Over 75 years of age health checks were not routinely offered but the practice was participating in a pilot scheme where patients of 83 years of age were asked to complete a health questionnaire and offered a health check if felt necessary based on the information provided.

The practice were also in the process of appointing a part time 'community' GP for an initial trial period of 6 weeks commencing June 2015. This GP would be responsible for the care of patients who were mainly housebound and, potentially, palliative care patients and those requiring cancer reviews. If the pilot proved to be successful the practice hoped to be able to secure the funding to continue with the scheme.

The practice could demonstrate that it had considered suggestions for improvement and changes to the way services were delivered as a consequence of feedback from patients. This had included the implementation of a post box outside the main entrance door to enable repeat prescription requests to be left without the need to queue at reception and updating the clinical rooms with new blinds and furniture. The practice had an active patient participation group (PPG) consisting of 22 members which met on a monthly basis. The practice was advertising for more members and hoped to encourage patients from other demographics to join.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of people in the planning of its services. The practice had access to a telephone translation service if required for those patients for whom English was not their first language. The practice also maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all patients had equal opportunities to access the care, treatment and support they needed.

The premises were situated in a single storey building which met the needs of people with disabilities. The reception area, treatment and consultation rooms were all accessible by those with mobility difficulties and there was step free and wheelchair access to the building through electrically operated sensor driven doors.

The practice had male and a female GPs, which gave patients the ability to choose to see a doctor of a particular sex if preferred.

Are services responsive to people's needs?

(for example, to feedback?)

Patients were easily able to register with the practice and patients who were not registered, such as holiday makers or those of no fixed abode were able to access appointments. On the day of our visit we spoke to a family holidaying in a nearby holiday park that had been able to get a same day appointment for their baby who had taken ill.

Access to the service

Surgery opening times were between 8am to 6.30pm on a Monday, Tuesday and Friday and between 8am and 8.30pm on a Wednesday and Thursday. The first appointment was 30 minutes after surgery opening time and the last appointment was 30 minutes before surgery closing time.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered lunchtime appointments and extended opening hours up to 8.30pm on two nights per week to ensure the needs of people who worked and students could be accommodated. 57.9% of the practice population were reported to be in work or full time education compared to the national average of 60.2%.

The majority of the patients we spoke with and those who completed Care Quality Commission (CQC) comment cards said they were satisfied with the appointment system operated by the practice. Of the patients who participated in the 2014 national GP patient survey published in January 2015, 77% said they could easily get through to someone at the practice on the phone (national average 75%) and 81% stated they were satisfied with the practice opening hours

(national average 79%).

Appointments could be booked in the surgery, by telephone or on line. We looked at the practices' appointment system during our inspection and found that an urgent appointment was available with a member of the duty team (this could be either a GP or a nurse practitioner) the same day. The next routine appointment available with a GP was three weeks later on the 2 June 2015. However a routine appointment was available with an F2 doctor the previous week. Children requiring an emergency appointment were seen the same day. Requests for home visits were considered by the GPs on a case by case basis and were carried out throughout the day. Telephone consultations were available by appointment.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed there was an answerphone message advising the called to ring the NHS 111 service for further advice and guidance.

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. The practice manager was the designated responsible person for handling all complaints and would investigate complaints in conjunction with the GP partners.

We saw that a leaflet detailing how to make a complaint was available to patients and that this was last reviewed in April 2015. This gave details of how to escalate a complaint to the Parliamentary and Health Service Ombudsman should the complainant remain dissatisfied with the response received from the practice. This information was also available on the practice website.

The practice had received 18 complaints for the period 1 April 2014 to 31 March 2015. We found that complaints had been dealt with appropriately. Face to face resolution meetings were often offered and apologies issued where a complaint was felt to be justified. Lessons learned and matters arising from complaints were disseminated to practice staff via team meetings and practice learning time with the aim of improving service delivery. One complaint had escalated to and was currently being considered by the Parliamentary and Health Service Ombudsman with the cooperation of practice staff.

One of the GP's was able to give us an example of a complaint which had resulted in the patient receiving an apology. The GP told us that complaints were often resolved with the offer of a face to face meeting to discuss concerns.

Staff were able to give us examples of where action had been taken when concerns had been identified. This had included working with the local NHS trust to ensure improvements were made to the car park following a major accident in the car park in 2013. In addition arrangements were made to allow staff to park off site to release more spaces for patients use.

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. This was clearly outlined in their mission statement which stated 'We will deliver a high quality of health care which is patient centred, dynamic and promotes an appropriate level of continuity with the resources available. We will encourage an environment of mutual respect, trust and support and create a culture of optimism and positivity'. Staff told us they knew and understood what the practice was committed to providing and what their roles and responsibilities were in relation to these.

The practice did not have a written business plan but the practice manager told us that the GPs and management team had held an 'away day' where the future aims and objectives of the practice were discussed and agreed. This had included succession planning as two of the GP partners were leaving later in 2015. Recruitment to replace the GPs was ongoing. The practice manager accepted the need to include all staff (both clinical and non-clinical) in the business planning process to ensure the development of effective person centred care.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, the executive partner was the lead for palliative care and other partners were the leads for child protection, vulnerable adults and medicines management. The executive partner was also the Caldicott Guardian (member of staff responsible for protection patients' confidentiality and enabling appropriate information sharing). We spoke with several members of staff who were all clear about their own roles and responsibilities as well as the roles of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures which were up to date.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance and the GPs were allocated protected time to consider QOF related issues. Where concerns were identified the practice actively sought to combat this. This included investigating issues when the practice had been identified as an outlier for the percentage of patients with atrial fibrillation, measured within the last 12 months, who are currently treated with anti-coagulation drug therapy or anti platelet therapy.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality, risks and issues outstanding from previous meetings had been discussed.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example a risk assessment had been carried out for a pregnant member of staff and in relation to cleaning activities. Any risks relating to individual patients were recorded on the patient's record to alert staff of any potential concerns.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. A staff handbook was available which all staff were required to sign to signify they had read and understood the content. Policies and procedures were easily accessible both electronically and in paper format. All new staff went through an induction process and an induction pack was in existence.

We found there were good levels of staff satisfaction which had resulted in a stable workforce and good staff retention rates. Staff we spoke with were proud of the practice and felt it was well led and a good place to work. They told us there was an open and honest culture within the practice and they were happy to raise issues both informally and during team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had carried out a patient survey in January 2015. The results of this survey had shown that areas of dissatisfaction included the length of time taken to answer phone calls; being able to see a GP or nurse of choice; the

Are services well-led?

Good 

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

length of time spent waiting to see a clinician after the appointment time and convenience of appointment dates and times. The practice had responded to this by discussing the issues during a practice learning time session where it was agreed that staff rotas be reviewed to ensure more staff were on duty at times of high demand. In addition practice meetings were re arranged so they did not clash with busy periods and more consideration was to be given to telephone consultations. Implementation of the changes, which the practice intends to monitor for improvement, took place in April 2015. Results of the survey were published on the practice website.

The practice had also signed up to the 'I Want Great Care' campaign where patients can provide feedback on the care afforded to them by GP practices and hospitals. Details of how to do this were provided on the practice website. Comments on the 'I Want Great Care' website that we viewed post inspection were positive and the practice had been rated as 4.5 out of 5 from 108 reviews.

An active patient participation group was in existence and had joined the National Association for Patient Participation Groups to gain a better understanding of the role of the PPG. The PPG had identified several aims and objectives for the coming year. This included promoting on-line services for booking appointments and ordering repeat prescriptions; making more information available to patients who had registered to the patient access online service (such as allergies and immunisations) and improving communication with secondary care providers. Past improvements as a result of PPG involvement have included the installation of a repeat prescription post box

outside of the main entrance so there was no need to queue at reception, adding pictures and magazine/leaflet racks to the waiting room and updating clinical rooms with new blinds and furniture.

The practice gathered feedback from staff through staff meetings and on a more informal day to day basis. Staff we spoke with told us they regularly attended staff meetings and felt these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

A whistle blowing policy was in place which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop. Practice nursing staff told us they had opportunities for continuous learning to enable them to retain their professional registration and develop the skills and competencies required for chronic disease management. Regular staff appraisals were taking place and personal development plans identified.

The practice had regularly reviewed significant events and other incidents with a view to identifying any trends or themes and determine learning opportunities. These events were shared with relevant staff as and when appropriate through team meetings.

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.

This section is primarily information for the provider

Enforcement actions

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.