Hall Green Health

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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hall Green Health on 19 May 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice inadequate for providing safe services and requiring improvement for being well led. It also required improvement for providing services for the six 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 and people experiencing poor mental health (including people with dementia). This is because the concerns that have led to the overall provider rating apply to everyone using the practice, including these population groups. The practice was good for providing an effective, caring and responsive service.

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

- Most staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. However it was not always clear that learning was shared consistently to all relevant staff.
- Risks to patients were assessed and managed but systems were not always robust and we identified weaknesses in the management of risks relating to medicines and vaccinations.
- Data showed patient outcomes were in line with other practices and sometimes higher than other practices in the locality. Audits undertaken helped to further drive improvement in the performance and patient outcomes.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. There were robust systems in place for the management of patients with long term conditions.
- Patients said they were treated with compassion, dignity and respect and they were involved in their

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care and decisions about their treatment. However, they raised concerns in relation to access to appointments which the practice was endeavouring to address.
- Information about how to complain was not easily visible to patients to enable them to make a complaint, although complaints seen had been appropriately managed.
- A triage system was in place so that patients who needed to be seen the same day received a consultation on the day and if necessary were seen in person.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure. However, it was not clear that the arrangements in place supported an open and transparent service with proactive feedback from all staff groups and the sharing of learning to all relevant staff.

The areas where the provider must make improvements are:

- Ensure appropriate systems are in place to manage the cold chain for vaccinations.
- Maintain robust systems for checking medicines and single use equipment are within date and fit for use.
- Ensure appropriate criminal checks are in place for relevant staff and where these are not deemed necessary roles should be risk assessed to ascertain why and mitigate any potential risks to patients.

In addition the provider should:

- Develop a culture in which all staff are aware and confident in the reporting of incidents (clinical and non-clinical) and where relevant staff are involved in the learning and feedback from these.
- Develop systems for maintaining staff training records so that the practice can be assured that training relevant to staff roles has been completed and any identified development needs are met.
- Ensure policies included in the staff induction handbook are kept up to date to ensure staff are using the latest information and guidance.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. There were systems in place for raising concerns, reporting incidents and near misses and evidence of learning from those. However it was not clear that all staff within the practice were aware of the processes and fully involved in the learning. We found robust arrangements in place for managing safeguarding concerns and following up of vulnerable patients. However patients were at risk of harm because there were weaknesses in the systems and processes for managing risks relating to medicines and vaccinations and recruitment.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned appropriately to meet their needs. There were robust arrangements to identify, review and monitor patients with long term conditions and complex needs. There was a good skill mix of clinical staff and support networks for staff to help meet the needs of patients. There was evidence of appraisals and personal development plans for staff. Multidisciplinary working with other providers was taking place but usually on an informal basis. However, feedback from health professionals working outside the practice indicated good working relationships. Health promotion and prevention was carried out within the practice.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and the practice engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services. Services provided from the practice provided greater flexibility and convenience to patients who needed to be seen regularly. Patient feedback had identified access to appointments as an issue. However, the practice had

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undertaken action to try and improve this aspect of the service and ensure patients were able to obtain access to a clinician on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Patients with mobility difficulties were able to access the practice. Complaints received were recorded, investigated and responded to appropriately. Information about how to complain was available and learning was evident.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff were aware of this. There was a documented leadership structure and most staff felt supported by management. However, issues identified during the inspection indicated a culture that was not always open and inclusive of all staff within the organisation. The practice had a number of policies and procedures to govern activity, but there was evidence that these were not always being followed. Governance meetings were regularly held but consisted mainly of senior management. The practice had sought feedback from patients and had an active patient participation group (PPG). Staff received induction training and performance reviews with the focus on learning and development clearer for clinical than non-clinical staff.

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

Requires improvement

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

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Patients aged over the age of 75 years had been allocated a named GP. Nationally reported data showed outcomes for patients were good for many conditions including those commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, unplanned admissions and dementia care. Meetings were held to discuss and manage the needs of complex older patients. Health checks were also available for those over 75 years. The practice was responsive to the needs of older people, and offered home visits and services such as the anticoagulation clinic locally to patients. Systems were in place to ensure patients with urgent needs would receive a same day consultation either by phone or in person. We received positive feedback on the practice from the managers of two homes for older patients and the district nursing team on the practices support and care of end of life patients.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

National data showed the practice performed well in the management of patients with long term conditions. Clinical staff had lead roles in the management of long term conditions and attended external meetings to update and share knowledge. Nursing staff had been trained and led clinics for the management of patients with diabetes, rheumatology, asthma and chronic obstructive pulmonary disease. There were dedicated staff who were responsible for calling patients for their reviews and in the case of diabetes recall was based on need rather than routine appointments and longer appointments were allocated for these reviews. Anticoagulation clinics were also available on site and covered extended opening

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hours for the convenience of patients that needed regular monitoring. There had been improvements made in the up-take of patients at risk with the flu vaccination between 2013/14 to 2014/15 from 34.9% to 52.2%.

Practice data showed that all patients identified with complex health needs for the unplanned admissions enhanced service had care plans in place. Daily meetings were held at the practice to discuss admissions and discharges within the previous 24 hours and the management of these patients. Conversations with members of the district nurse team told us that there were good working relationships between the practice and their team. However, there were currently no formal meetings held with health professionals outside the practice whose input may be required to formally discuss these patients needs

Families, children and young people

Requires improvement

The practice is rated as requires improvement for families, children and young people.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

There were robust systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, those at risk were identified on the patient record system and if they tried to cancel an appointment the GP would be made aware and the patient followed up. Those who did not attend immunisation clinics were also followed up. Data available to us for 2013/2014 showed immunisation rates were higher than the CCG average for all standard childhood immunisations. However, we identified issues during our inspection with the way in which vaccinations had been stored and monitored to ensure their effectiveness. Appointments were available outside of school hours and the premises were suitable for children and babies. We received positive feedback from the health visitors about the working relationship with the practice.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for working age people (including those recently retired and students).

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Patients were able to book appointments with the practice including appointments with their chosen GP at any time online or

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through the automated telephone booking service. Extended opening hours were available on a Saturday morning. There were also specific clinics and services available outside normal opening hours including anti-coagulation clinics and phlebotomy services. This provided greater convenience to patients who worked or had other commitments during the day. NHS Health checks were offered to patients aged between 40 to 75 years. Practice data showed that 4618 (17%) of patients in this age group had taken up the offer of the health check. Data available showed the uptake of cervical screening was higher than other practices in the CCG. Sexual health clinics and chlamydia self-testing was available at the practice.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

The practice had identified their most vulnerable groups as those with learning disabilities and drug addiction. They had also identified those vulnerable due to their complex needs and offered enhanced services in these areas. An enhanced service is a service that is provided above the standard general medical service contract (GMS).

Practice data showed 100% of patients with complex health needs had care plans in place so that their needs could be met. However, only 20% of patients on the learning disability register were reported as having received a health review during 2014/15. The practice had introduced learning disability passports for patients which contained important information about the patient including their likes and dislikes should they be admitted to hospital. During 2014/15 the practice had also established a carers register and was continuing to advertise and promote the register to attract new carers; we were told the carers register currently contained the details of over 500 patients.

Staff had been trained to understand the signs of abuse in vulnerable adults and children and were able to identify which patients were most vulnerable. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies responsible for investigating safeguarding concerns.

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People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the people experiencing poor mental health (including people with dementia).

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The latest data available to us for 2013/14 showed that the proportion of people experiencing poor mental health receiving an annual physical health check was in line with other practices in the CCG area. The practice was participating in the dementia screening programme enabling earlier referrals to be made.

The practice had enhanced shared care agreements in place for patients on mental health medication. Staff told us they were working with the local mental health services to try and develop clearer lines of responsibility and prescribing across services to best support this group of patients and provide good continuity of care.

Summary of findings

What people who use the service say

As part of the inspection we spoke with 23 patients who used the practice. This included three members of the patient participation group (PPG). PPG are a way in which practices can work closely with patients to improve services. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they had received. We received 31 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were generally happy with the service they received. Patients told us that they were treated with dignity and respect and felt listened to. Although there were a small proportion of patients who felt reception staff could be abrupt.

The main frustration cited by patients was obtaining an appointment. This was also raised as a significant issue in the latest GP national patient survey (2014) and an in-house patient survey of 400 patients undertaken in February 2015. We saw that the practice had taken action to try and improve access and some patients commented that they had recently seen an improvement.

We spoke with the managers of two care/nursing homes supported by the practice and health professionals who worked with the practice. We received positive feedback about the working relationships with the practice. The managers from the two care homes also told us that they were happy with the support the practice gave to patients living in these homes.

Areas for improvement

Action the service MUST take to improve

- Ensure appropriate systems to manage the cold chain.
- Maintain robust systems for checking medicines are within date and fit for use.
- Ensure appropriate criminal checks are in place for relevant staff and where these are not deemed necessary roles should be risk assessed to ascertain why and mitigate any potential risks to patients.

Action the service SHOULD take to improve

- Develop a culture in which all staff are aware and confident in the reporting of incidents (clinical and non-clinical) and where relevant are involved in the learning and feedback from these.
- Develop systems for maintaining staff training records so that the practice can be assured that training relevant to staff roles have been completed and any identified development needs met.
- Ensure policies included in the staff induction handbook are kept up to date to ensure staff are using the latest information and guidance.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GPs, a practice manager, a practice nurse and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Hall Green Health

Hall Green Health is part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG).

Hall Green Health is registered with the Care Quality Commission to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

The practice is located in a purpose built health centre which it shares with various services provided by Birmingham Community Health. The practice also has a branch surgery on Shirley Road, Acocks Green. We did not visit the branch surgery during our inspection. Based on data available from Public Health England, deprivation in the area served is higher than the national average. The practice has a registered list size of approximately 27,000 patients.

The practice is open 8.30 am to 6.30pm on Monday to Friday, with the exception of Wednesday when the practice closes at 1.00pm. Extended opening hours are available on Saturday mornings. When the practice is closed on a Wednesday afternoon and during the out of hours period (6.30pm to 8.30am) patients received primary medical services through an out of hours provider (BADGER).

The practice has 16 partners and five salaried GPs. Other practice staff consist of a team of 11 nurses (including three nurse practitioners), five healthcare assistants, a management team and a team of administrative staff. The practice is also a training practice for doctors who were training to be qualified as GPs.

Why we carried out this inspection

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

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?

Detailed findings

- 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 19 May 2015. During our visit we spoke with a range of staff (including GPs, nursing, management and administrative staff) and spoke with 23 patients who used the service. We looked at a range of documents that were made available to us relating to the practice, patient care and treatment. We also spoke with patients who used the service. Prior to the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 31 completed cards where patients shared their views and experiences of the service.

Inadequate

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. Clinical staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses, however this did not extend to the reception staff we spoke with. The business manager told us that the team leaders who managed the reception team would usually report any incidents that were alerted to them.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term. In one example we saw that there had been an incident in which an epipen (used to treat anaphylaxis) was prescribed to a child. The dosage had been too low to be effective and had identified that weight needed to be taken account rather than a child's age when prescribing this medicine. Analysis of the incident showed strong evidence of learning resulting from the incident which was also shared with the local area network of GP practices to minimise the risk of future reoccurrence.

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 12 months and we were able to review these. There was comprehensive reporting of incidents and evidence of learning taking place. However, this mainly focussed on clinical events that had occurred. Staff told us that significant events and complaints were routinely discussed at the weekly clinical meetings. All clinical staff were invited to these meetings and they were also attended by the business manager and patient services manager who were able to disseminate any relevant information to their teams.

We saw copies of incident forms used by staff which when completed were collated by the practice manager. Those we reviewed had been completed in a comprehensive and timely manner. However, it was not clear from evidence available and discussions with various staff groups that all knew how to raise an issue for consideration; that learning reached all staff within the practice or that patients affected when something had gone wrong had been contacted to apologise or discuss the implications. For example where an admission to hospital may have been prevented.

National patient safety alerts were collated by the business manager for discussion at the weekly clinical meetings. Staff we spoke with were able to demonstrate robust processes for managing alerts and gave us examples of medicine alerts that had been acted on.

Reliable safety systems and processes including safeguarding

The practice had robust systems to manage and review risks to vulnerable children and adults. Safeguarding training was considered mandatory at the practice. We looked at training records which showed that most staff had received relevant role specific training on safeguarding. There were policies in place for children and vulnerable adults and domestic violence which described what abuse might look like and what to do if abuse was suspected. The policies were accessible to all staff on the computer system. Staff we spoke with were aware of their responsibilities to share information about safeguarding concerns with relevant agencies responsible for investigating and some staff were able to provide examples where they had done this. Contact details for the relevant agencies were easily accessible. Information relating to safeguarding was displayed throughout the practice including information on how to contact the relevant agencies.

The practice had a clinical (GP lead) and administrative lead for safeguarding vulnerable adults and children who were trained to the appropriate level and able to provide advice and support to other members of staff. All staff we spoke with were aware who these leads were if they needed to discuss any safeguarding issues.

There was a system to highlight vulnerable patients on the practice's electronic records. The practice had a dedicated member of staff who processed safeguarding information as a priority. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. A code was used which alerted staff if a

patient was vulnerable and if a patient with this code tried to cancel an appointment the GP would be alerted and further contact with the patient made. There were systems to follow up patients who do not attend immunisations.

Health visitors who shared the same building as the practice had access to the practice's clinical system so that important information could be shared. We spoke with health visitors on site who told us that they had a good working relationship with the practice and that they regularly discussed vulnerable children with practice staff.

There was a chaperone policy in place. Notices were visible in the clinical rooms to ensure patients were aware that they could request a chaperone to be present during their consultation. 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. Staff including, nursing, health care assistants and reception staff undertook chaperoning duties. We saw evidence that some staff had received training but the way in which training records were organised made it difficult to determine whether all relevant staff had received training.

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 stored in the refrigerators were kept at the required temperatures (cold chain policy), which described the action to take in the event of a potential failure. However, the processes for following this policy were not robust and we identified serious concerns with the management of the cold chain. Monitoring of the fridge temperatures was carried out by the security guard who did not demonstrate a clear understanding of this role.

The provider had six medicine refrigerators for the storage of vaccines. We found issues with three of these. Recordings seen showed that the refrigerator temperatures had been checked daily. However records for the main fridge showed that the temperatures had been consistently outside the required range for the safe storage of vaccines during May 2015. Temperatures recorded for May 2015 ranged between minus 4.3 and 20.2°C. Two other fridges did not record minimum and maximum temperatures which would enable staff to see if there had been any problems with the fridge which may impact on the effectiveness of the vaccines. We raised these issues with the practice who immediately took appropriate action and were working with the immunisation team at Public Health England to take any corrective action and minimise any further risks to vaccines stored at the practice.

We also found the practice did not have robust processes in place to check medicines were within their expiry date and suitable for use. We undertook random checks of vaccines and found they were in date. However, we found two medicines that might be required in an emergency that were past their expiry dates. These medicines had expired in September 2014 and February 2015. We alerted staff so that the medicines could be immediately removed from potential use.

The practice had a clinical lead for prescribing. We saw that the practice participated in prescribing benchmarking through the CCG. This showed comparative prescribing patterns for a range of medicines such as antibiotics and hypnotics. This showed that prescribing was in line with other practices in the CCG area. We saw examples of medicines audits undertaken which showed evidence of improved prescribing for example, antibiotic prescribing.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. There was a robust recall system for patients with complex health care needs to have regular health reviews in which medicines would be checked. The practice also held dedicated clinics for patients on anti-coagulants and rheumatology patients where they underwent regular monitoring. An alert system was used to indicate where patients were on high risk medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely at all times and signed out when required.

Cleanliness and infection control

We observed the premises to be well maintained and visibly clean and tidy. The cleaning of the premises was contracted out to another provider and cleaning schedules were in place. Staff told us that spot checks were undertaken every six months and records were maintained of these. Patients we spoke with told us they found the

practice clean and had no concerns about cleanliness or infection control. An infection control audit had been undertaken in March 2015 but had not raised any major concerns.

The practice had a lead for infection control who we saw from training records had undertaken recent refresher training in this area. All staff could access infection control training through online training available. Due to the way in which records of training were maintained it was difficult to verify which staff had undertaken this training.

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. These were accessible to staff on line and included issues such as hand washing, personal protective equipment and needle stick injuries. The policies had been reviewed regularly, although some of the supporting policies were not directly relevant to the practice.

Appropriate hand washing facilities were available for staff in the clinical areas. Notices about hand hygiene techniques were displayed and personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Wipes were also available for cleaning surfaces and equipment between patients.

The practice had undertaken a risk assessment to manage the risks of infection to staff and patients from legionella (bacteria which can contaminate water systems in buildings). We saw evidence of actions taken in response to minimise the risks to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment had been tested within the last 12 months. We also saw evidence of calibration of relevant equipment; for example fridge thermometer, pulse oximeters and defibrillator.

We found items of single use, such as needles and syringes that had past their expiry dates among emergency equipment in the practice.

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 the recruitment records for five members of staff that had recently been recruited. This included both clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, for a non-clinical member of staff there was no DBS check in place; the records referred to a DBS check protocol which identified the need for a line manager's assessment but none was available.

We were told that practice policy was for all new staff to have DBS checks. Staff also told us that they were reviewing DBS checks for existing staff and we saw evidence of checks that had been sent, some of which had been returned and others were waiting to be returned. We checked the list of staff who undertook chaperoning duties and found five had DBS checks in place, six had evidence of DBS checks being sent but not returned and four had no evidence that they had been sent. None of the staff without a DBS check had risk assessments in place.

Staff told us there were enough staff to maintain the smooth running of the practice and keep patients safe. There were arrangements in place to cover for staff absences. Staff told us that there was sufficient flexibility with clinical staff to cover for each other. For example the GPs worked in buddy teams of five and would provide cover for each other in their buddy team. Reception staff would cover any extra hours when needed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We found the premises were well maintained and a security guard was available on site if needed. The practice told us that they did not own the building but told us that they undertook regular spot checks of the premises but did not formally record these. The practice had a health and safety policy and also covered this in the new staff induction.

However, there were robust processes for managing risks for patients with complex or deteriorating health needs and for those who were vulnerable. Systems were in place to

identify and follow up patients who were at risk. This included daily meetings to discuss patients that had been admitted and discharge from hospital. As well as regular reviews for patients with long term conditions.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Training records showed that most staff had received recent training in basic life support. However, practice records showed that six members of clinical staff (four GPs and two nurses) had not. Following the inspection the practice confirmed all clinical staff had received this training. 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, most knew the location. Staff told us that emergency equipment was checked regularly but no records were available to verify this. However we saw that both the oxygen and defibrillator were in good working order.

Emergency medicines were available in a secure area of the practice and most staff knew of their location. Anaphylaxis boxes were also available in each treatment room (used for the treatment of severe allergic reactions). Medicines seen covered a range of potential medical emergencies. Records showed that these were checked on a monthly basis to ensure they were within their expiry date and suitable for use.

A disaster plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The disaster plan was held offsite to ensure it was available if needed. The plan covered a range of risks and mitigating actions recorded to reduce and manage risks such as power failure, fire and floods. The document also contained relevant contact details for staff to refer to.

There were arrangements in place to maintain fire safety. Fire training was covered as part of the induction training for new starters and the practice had named fire marshals in the event of an evacuation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines and best practice was discussed at clinical meetings and we saw evidence of this relating to diabetes medicines and the management of atrial fibrillation. We also saw examples of guidance that had been discussed at a nurses meeting relating to childhood vaccinations. Staff told us about NICE guidance they had accessed on line and about templates they used for patients with asthma and chronic obstructive pulmonary disease (COPD) to ensure consistent care.

Clinical staff took lead roles in various specialist clinical areas such as asthma and COPD, palliative care and rheumatology. The nursing team supported this work, which allowed the practice to focus on specific conditions. Clinical staff met regularly which enabled them to support each other and described good support mechanisms from colleagues when needed.

The practice showed us data from the local CCG of the practice's performance for antibiotic prescribing (December 2014 to February 2015) which showed the practice antibiotic prescribing was comparable to similar practices and showed improvement.

The practice had systems in place to review patients recently admitted and discharged from hospital. Daily post discharge meetings were held to discuss these patients which enabled any potential care needs and follow up to be identified.

Information made available to us showed that the practice had higher rates than average of attendances to accident and emergency, emergency admissions and outpatient referrals than other practices within the CCG area. The practice had considered this in conjunction with the results of their in-house patient survey (February 2015) where issues had been raised around access to appointments. An action plan had been produced and action was in progress to try and improve access to the service and reduce emergency attendances.

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. There was a strong emphasis on chronic disease management and clear roles helped ensure patients who were vulnerable or had complex needs were kept under review. There was a dedicated team of staff who were involved in checking and recalling patients to ensure that all routine health checks were completed. For long-term conditions such as diabetes, follow up was patient centred and based on need and risk to the patient rather than routine.

The practice showed us several examples of clinical audits that had been undertaken in the last year. Some of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. They included improved antibiotic prescribing and improved outcomes for patients with asthma. The practice had also carried out an audit of ambulatory care sensitive conditions. These are conditions that can be appropriately managed in the primary care setting such as asthma, diabetes and hypertension. The practice had been identified as having higher levels of emergency admissions to hospital for these conditions. The focus of the audit was to review emergency admissions on a monthly basis to identify inappropriate admissions and where further action could have been taken to prevent the admission, with learning reported back to clinicians as necessary. As a result of this admissions were discussed at daily meetings where admissions and discharges in the previous 24 hours were discussed to help better manage this group of patients.

The practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The latest information available to us for 2013/14 showed the practice's performance against QOF was in line with other practices nationally and the total QOF points achieved was 882 out of a total of 900

Good

Are services effective?

(for example, treatment is effective)

points available overall. The practice showed us their performance against QOF for 2014/15 which showed 94% of diabetic patients and 95% of patients with COPD had received an annual medication review.

The practice is part of the Birmingham Cross City Clinical Commissioning Group (CCG) who are offering all practices within their CCG the Aspiring to Clinical Excellence (ACE) programme. The ACE programme is based on the strategic objectives of the CCG and the NHS Outcomes Framework indicators. ACE is a programme of improvement aimed at reducing the level of variation in general practice by bringing all CCG member practices up to the same standards and delivering improved health outcomes for patients. There are two levels, ACE Foundation and ACE Excellence. The practice is currently working to achieve the ACE foundation level whose priorities for 2014 to 2015 are on engagement and involvement, medicines management, quality and safety, carers, safeguarding and prevention. We saw that areas for the practice to improve had been identified and that the practice had taken action to address these for example patient survey data, accident and emergency attendances and safeguarding.

The practice also participated in local benchmarking run by the CCG and worked with a local clinical network of nine practices. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice compared well in most areas relating to patient outcomes but was lower in terms of patient satisfaction. The practice had put in place action plans to try and improve patient satisfaction.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. There was a large clinical team consisting of 16 GP partners and five salaried GPs, 11 nurses including three advanced nurse practitioners. We noted a good skill mix among the doctors and nurses with a number having additional diplomas and areas of special interest.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

The practice had invested in online training which covered a range of areas such as information governance, equality and diversity, safeguarding, end of life care, mental capacity and infection control. This was available for all staff.

New staff received induction training which included health and safety, fire safety and safeguarding. We saw copies of the policies and procedures which staff were required to view in their induction. Locum GPs also received an induction pack to support them when covering sessions at the practice.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and 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.

Staff undertook annual appraisals that identified and documented learning needs. We saw evidence from nine appraisals that had been completed within the last 12 months. Our interviews with staff confirmed that the practice was proactive in providing training although this was more evident with clinical staff.

As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP at all times who provided support when needed. We received positive feedback from one trainee we spoke with who told us that they felt well supported.

Following patient feedback on patient satisfaction the practice had introduced a performance policy for reception staff. Reception staff were monitored against various performance targets and competencies which were related to pay. We saw evidence of regular supervisions and evidence of action taken to improve performance and the patient experience.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service

Good

Are services effective?

(for example, treatment is effective)

both electronically and by post. These were managed by a dedicated staff who would identify and alert clinical staff if information was received for any of the patients identified as having complex care needs.

The practice was commissioned for the new enhanced service for unplanned admissions and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. The practice held daily discharge meetings to review patients identified as part of the enhanced service that had been admitted to hospital. This enabled the GP to follow up and discuss whether the admission could have been avoided and how patients could be best supported. We also saw evidence of the practice nurse leading on diabetes attending hospital multi-disciplinary team meetings to discuss some of the more vulnerable patients.

The practice had held multi-disciplinary meetings with other health care professionals but this had not been recently. However, the practice shared the premises with various services provided by Birmingham Community Health such as district nurses, school nurses, health visitors, physiotherapists and speech and language therapists. We spoke with health visitors and district nurses who were on site during our inspection. They were very positive about the joint working relationship for example around end of life care. We saw minutes of meetings with the mental health team to discuss and improve working arrangements for patients receiving shared care.

The practice was contracted to provide a local anti-coagulation service. Not all patients who attended this clinic were patients at this practice. We saw evidence that the practice worked with the patient's usual GP and discussed the patient's care when needed.

Information sharing

The practice used various systems to communicate with other providers. For example, referrals were made through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Information was also shared with the out of hours service via fax to ensure continuity of care for patients who may need to use this service.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. Staff were trained to use the system, and were happy that it worked well. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff knowledge of the Mental Capacity Act 2005 and their duties in fulfilling it was variable. There was information relating to mental capacity and best interest decisions displayed throughout the practice and evidence that some staff had received training in this area.

The practice was able to provide examples as to how it supported patients where capacity may be an issue. For example the practice told us that 44% of patients on the learning disability register had learning disability passports in place. This ensured important information about the patient was recorded in conjunction with the patient so that their wishes, likes and dislikes could be taken into account if they were admitted to hospital. The practice was also able to show examples where lasting power of attorney decisions had been made so that the GPs were aware of a patient's wishes should they lack capacity in the future.

We spoke with the managers of two homes for elderly patients. They told us that the GPs who visited the home would involve patients and families in end of life care planning and do not attempt resuscitation orders.

There was a practice policy for documenting consent for specific interventions. We saw examples of consent obtained for seeing medical students and for fitting contraceptive devices.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 4618 (17%) of patients in this age group had taken up the offer of the health check during 2014/15. This compared to 24.4% of patients in the Birmingham area that had taken up the offer of an NHS Health Check. Nursing staff told us that if there were any concerns the patient would be referred for a follow up appointment with a GP.

Other health and screening checks carried out by the practice included health checks for babies at six to eight

Good

Are services effective?

(for example, treatment is effective)

weeks which incorporated post natal checks on mothers. Memory testing was also offered to patients to support earlier diagnosis of dementia and referrals to specialist care. The practice kept a register of all patients with a learning disability and practice data showed 37 out of 186 (20%) of patients on the register had received an annual physical health check during 2014/15. Self-testing for chlamydia screening was also available from the practice.

The practice nurse we spoke with told us about additional support that they offered to patients for example, nurse run smoking cessation and weight loss clinics and referrals to health trainers to help support patients to lead healthier life styles. Staff told us about information they could give to patients about various support agencies, such as diabetes UK, where the patient could find out more about their condition and the falls prevention service.

The practice's performance for cervical screening uptake was 93.5%, which was higher than other practices nationally at 82%. Letter reminders were sent to patients who did not attend for cervical screening. This was undertaken by a dedicated member of staff.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Feedback from the local CCG told us that the practice had performed well against targets for flu vaccinations and immunisations during 2014/15 and had made improvements from the previous year. Data from the practice showed an improvement in the uptake of flu vaccinations for at risk groups between 2013/14 and 2014/15. For example, the uptake of flu vaccines for patients over 65 years at risk had improved from 60% to 82%. Uptake of childhood immunisations was also higher than the CCG average for all standard childhood immunisations during 2013/14.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP national patient survey (2014) and an in-house patient survey of 400 patients undertaken in February 2015 in conjunction with the practice's patient participation group (PPG). The evidence from these sources showed most patients were satisfied with how they were treated and that this was mostly with compassion, dignity and respect. However, data from the GP national patient survey 2014 showed the practice was below the national and local clinical commissioning group (CCG) average for patients who rated their overall experience as good or very good (67% compared to the CCG average of 82%). The practice was similar to other practices on satisfaction scores on consultations with doctors and nurses with 90% of practice respondents saying the GP was good at listening to them and 91% saying the GP gave them enough time. The practice's in-house survey of 400 patients found 86% of patients responded that the GPs and nurses were good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the majority were positive about the service patients had experienced. We also spoke with 23 patients in person as part of the inspection. Feedback received told us that most patients were satisfied with the care they received from the practice, they found the service was caring and told us that they were treated with dignity and respect. However, some of the feedback we received was less positive and predominantly related to issues around access to appointments and attitude of staff. Our observations in the waiting area found that the manner in which staff spoke with patients was variable. These issues had been raised in the GP national patient survey 2014 and the practice's in-house patient survey 2015. We saw that the practice had developed comprehensive action plans in place to try and address these issues and some comments from patients indicated that actions being taken were starting to have an impact.

We saw that consultations and treatments were carried out in the privacy of a consulting room. We noted that treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Practice staff we spoke with were aware of the measures they needed to take to help maintain patients' privacy and dignity when undertaking examinations, investigations and treatments.

Staff were asked to read and sign a confidentiality policy when they first started to work for the practice so that they were clear about their responsibilities. There was an open reception desk and conversations between patients and staff could potentially be overheard. Reception staff told us and we saw a quiet room that was available if a patient wished to speak in private. None of the patients we spoke with raised any concerns about confidentiality at the practice.

A patient newsletter was available which identified issues of importance to patients. Such as raising awareness about the new telephone booking system, telephone triage system and flu vaccines.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients' responses to questions about their involvement in planning and making decisions about their care and treatment were in line with other practices nationally for GPs but lower than average for nurses. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 81% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decisions made about the care and treatment they received. They also told us they felt listened to and that staff took time to explain things in a way they could understand. This helped them to make an informed decision about the choice of treatment they wished to receive. We saw an anonymous example where patients had been involved in discussion about their health and treatment needs.

Data available from the practice showed that there were 365 patients with complex care needs, all had care plans in place in order to meet the care needs and wishes of patients. Feedback from the two care home managers we spoke with told us that the GPs involved patients and

Good

Are services caring?

families when planning end of life care needs for their residents. There was also positive feedback from district nurses, who shared the building with the practice, about the level of support for patients at end of life.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were satisfied with the emotional support provided by the practice and rated this area similar to other practices nationally. For example, 85% of respondents to the GP national patient survey said the GP was good at treating them with care and concern. Feedback from patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. Most patients told us that they found staff were caring. Others told us about information they had been given about their condition and other support services available.

During 2014/15 the practice had also established a carers register and was continuing to advertise and promote the register to attract new carers; we were told the carers register currently contained the details of over 500 patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them to discuss local needs and service improvements that needed to be prioritised. There was a range of services provided from the practice including anti-coagulation and rheumatology clinics and phlebotomy services (blood taking). This provided greater convenience and flexibility to patients who might otherwise need to attend hospital on a regular basis for the management of their condition.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are ways in which patients and the practice can work together to improve the service provided. Members of the PPG told us that they had in the past found the practice resistant to change and suggestions but this was improving. The PPG was proactive and had won a local award for the most improved PPG. We saw and the practice told us how the PPG had been involved in improving information available to patients.

We saw that the practice was responding to feedback from recent patient surveys. A comprehensive action plan had been put in place to address the concerns that had been raised by patients and the impact of actions being taken were being monitored for example, the time taken for reception staff to answer the telephone.

Tackling inequity and promoting equality

The practice was located in purpose built premises which it shared with the community health care teams. The entrance to the building was through automatic doors and there were several parking spaces available for patients with a disability. An assistance bell was available at the rear of the building where the doors were not automated. Patients were seen on the ground and first floors of the building. There was lift access to these floors. The practice was sufficiently wide to allow access for patients who used wheelchairs and those with pushchairs. Accessible to toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had not formally identified what proportion of the practice population were English speaking patients but told us that the majority of patients were a mix of white and Asian patients. We saw that information on the practice website and electronic booking in system could be translated into a range of different languages. Managers told us that if required they would book an interpreter although reception staff were not equally aware of the arrangements for this. Reception staff told us that there were staff that could speak second languages who were often used to interpret for patients.

Reception staff were not aware of any processes in place or what they would do to support patients in vulnerable circumstances such as those with 'no fixed abode', immigrants or asylum seekers who may wish to access the service. They told us that they had not encountered this.

Access to the service

Appointments were available from 8.30 am to 6.30 pm on Monday to Friday with the exception of Wednesday when the practice closed at 1.00pm. When the practice was closed Wednesday afternoons and during the out-of-hours period (6.30pm to 8.30am) patients received primary medical services through another provider (BADGER).

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 or automated telephone system. Those who required an urgent same day appointment were triaged by a GP by telephone to assess the patients need and if the patient needed to be seen in person an appointment was made. Approximately 25% of appointments were allocated for same day appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients on the practice website or through the practice answerphone.

Appointments could be booked at any time during the day using the online booking and automated telephone booking system. An electronic prescription service was also available. This provided greater flexibility to patients who had work or other commitments during the day.

Practice nurses who undertook reviews of patients with long term conditions told us that longer appointments were made available for patients who needed them. This

Good

Are services responsive to people's needs?

(for example, to feedback?)

also included appointments with a named GP or nurse. The practice carried out ward rounds at two care homes for the elderly under a retainer scheme. Managers of these homes told us they were satisfied with the support received from the practice. They told us that it was usually the same GPs who visited the homes which enabled good continuity of care for the patients.

However, satisfaction with the appointment system had been raised as an issue through the GP national patient survey and the practice in-house patient survey. The practice was below the national and local clinical commissioning group (CCG) average for patients who rated their overall experience of making an appointment as good or very good (49% compared to the CCG average of 69%). Patients who rated the practice as easy to get through on the telephone was also lower than the national and CCG average (29% compared to the CCG average 61%).The practice had put in place an action plan to address the issues raised and we saw that many of the actions had already been implemented. This included the implementation of online and telephone booking of appointments, promoting the use of the automated check in to free receptionist time to answer the telephones and a meet and greet person to direct patients who needed assistance. A telephone triage system had been introduced to ensure that patients who needed to see or speak with a GP on the same day did so. We received a mixed response from patients about the appointment system although some patients told us that they had recently noticed some improvement.

Most patients we spoke with felt they would be able to see a GP on the same day if they needed to and if they would be prepared to wait could see the doctor of their choice. The practice monitored waiting times and patients that did not turn up for their appointments on a daily basis.

The practice's extended opening hours were on a Saturday morning which was particularly useful to patients with work or other commitments during the day. The anti-coagulation clinic also started at 7.30am one morning each week to help accommodate patients who worked. Appointments were available outside school hours for children and young people.

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 complaints in the practice.

We saw a copy of the complaints form that patients could use to record their concerns. This included details of where to escalate the complaint to if the patient was not satisfied with the response received from the practice. Patients had to request a copy of the complaints form from reception which may prevent some patients from raising a complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at a recent report summarising complaints received during 2014/15. There were 85 in total. The most common themes occurring related to complaints about reception and prescriptions. Learning had been identified and implemented as a result. For example the reception management team had been restructured to provide greater support to reception staff and improve the patient experience.

We looked at three of the complaints in detail and saw that they had been investigated and responded to in a timely manner. We saw that one of the complaints reviewed had been referred to the Parliamentary and Health Service Ombudsman for resolution.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice did not have a formal business plan but partners openly discussed their vision for the future with us. Business planning was determined by senior staff within the organisation. The practice held monthly partners' meetings with voting rights to partners, the business and nurse managers within the practice when making decisions about the service.

We spoke with several members of clinical and non-clinical staff but not all were able to consistently describe the vision and values of the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on computers within the practice. The policies seen had been reviewed within the last 12 months and were up to date. However, the policies included in the staff hand book contained no review dates to ensure the versions held in them were the most up to date and that new staff were provided with current information. They also lacked specific practice guidance for staff to follow.

There was a clear leadership structure with named members of staff in lead roles. For example, a lead nurse for infection control and the senior partner was the lead for safeguarding. Clinical staff took lead roles for specific aspects of clinical care such as mental health and end of life care. We spoke with a range of clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Governance arrangements included executive committee meetings held every two weeks and comprised of five nominated partners, monthly partners meetings, weekly clinical meetings and daily post discharge meetings. These provided forums for discussing strategic direction, performance and quality and risks to the service.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. It also took part in local benchmarking with other practices.

Leadership, openness and transparency

Within the structure of the practice it was not clear that the culture of openness was effective and that relevant information was consistently disseminated where relevant to all staff within the practice. The emphasis of actions taken to address patient satisfaction had largely focussed on reception staff. We saw little evidence of reception staff involvement to the changes that had been made. However, staff we spoke with told us that they did feel able to raise issues at meetings they attended.

We saw an example of a significant event that occurred but discussions with staff did not indicate that the learning had been shared or contact attempted with the patient to explain or apologise about the situation. Members of the patient participation group had also identified a resistance to change from the practice but felt this was improving.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received. Results from these had been analysed and had identified common themes around access to appointments. We saw as a result of this the practice had introduced changes to release more time for reception staff to respond to telephone calls and ensure patients who needed to be see urgently were seen.

The practice had an active patient participation group (PPG) which was steadily increased in size. We spoke with three members of the group who told us that the practice had initially not been fully receptive to them but felt this was improving. There were currently 35 members of the PPG plus seven virtual members. There was a strong leadership within the PPG who had worked to raise the status and recognition of the group. The PPG had won an award from the CCG for turning around the group. The PPG chair told us that they had tried to enlist patients who were representative of the various population groups. For example looking at meeting times to encourage younger patients to attend and through virtual membership but this was still a challenge. The PPG had been involved in discussions relating to the in-house patient survey.

Staff meetings and informal discussions were the main forum for disseminating information and gathering feedback from staff. Staff told us that they felt they could

Are services well-led?

Requires improvement

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

raise issues but could not think of any specific examples. Many of the changes implemented in response to patient satisfaction had impacted on reception staff however we saw little evidence of their input into the changes.

The practice had a whistleblowing policy which was available to all staff on electronically. Staff were aware of the policy but none of the staff we spoke with told us they had needed to use it.

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 nine staff files and saw that regular appraisals took place which identified areas for learning and development. Clinical staff told us that the practice was very supportive of training and were able to give examples of courses that they had attended. For example, one nurse told us about the financial support and time given to attend course such as anticoagulation and relevant updates. We saw examples of learning events attended by staff at the practice for example around palliative care. There was however less evidence of training and support for reception and administrative staff within the organisation. We saw that responsibility for monitoring the cold chain had been delegated to a member of staff who did not demonstrate a clear understanding of the task they were undertaking or given appropriate support and supervision to ensure the task had been properly carried out.

The practice was a GP training practice. We spoke with a trainee at the practice who told us that they felt supported, had received induction training and had access to support from a senior GP at all times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use the service were not protected against the risks of unsafe care and treatment because:** **The practice could not be assured that vaccines stored at the practice were suitable for use due to weaknesses in the systems for managing the cold chain. Monitoring of the medicines refrigerator identified temperatures that would impact on the effectiveness of vaccines stored but no action had been taken in response to this.** **Medicines for use in an emergency were identified which had passed their expiry dates and so were unfit for use.** **Single use items of equipment such as needles and syringes were identified which had passed their expiry dates and so were unfit for use.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **DBS checks or appropriate risk assessments were not in place for all staff undertaking chaperoning duties.**