Northern Moor Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
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 Northern Moor Medical practice on 2/12/2015. Overall the practice is rated as requires improvement.

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

- GPs and staff described a system whereby significant events and near misses were reported by reception and administration staff. However the significant event record book behind reception used in this system had not had an entry completed since 2011.
- Clinical staff used templates to record and write up significant event analyses. When significant events were analysed, investigations were not always thorough enough. Staff were unable to tell us of the outcome of significant event analyses.
- Risks to patients were not comprehensively assessed nor well managed, for example those relating to recruitment checks and managing medical emergencies. The practice did not have a defibrillator on site; despite an incident in September 2014 where the practice identified the need to consider obtaining a defibrillator. There was no risk assessment to demonstrate the decision taken.
- Although some audits had been carried out, we saw limited evidence that audits were driving improvement in performance to improve patient outcomes.
- There were gaps in staff training and training was not well managed.
- Patients said they were treated with compassion, dignity and respect. They said they felt cared for, supported and listened to.
- Urgent appointments were available on the day they were requested.
- The practice had a number of policies and procedures to govern activity, but these were poorly managed. There was duplication, some were overdue a review and not all reflected practice's protocols.
- The practice had attempted to seek feedback from patients and had a patient participation group.

The areas where the provider must make improvements are:

Summary of findings

- Investigate safety incidents and significant events thoroughly and ensure action plans are completed and learning disseminated to staff effectively.
- Ensure a system is in place to manage, assess and mitigate risks to patients, for example those risks around medical emergencies.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there are appropriate policy documents in place to govern activity and that a system is in place to manage these documents.
- Ensure staff receive appropriate support, training and supervision to carry out their role, for example chaperoning, and that this training is managed to ensure its effectiveness.
- Ensure all clinical staff have appropriate medical indemnity insurance as required.

In addition the provider should:

- Ensure the infection prevention and control lead receives specific additional training to maximise the value added to this role.
- Ensure the practice manager has access to an appraisal process to identify training needs and support her in the role.
- Ensure cleaning processes are actively monitored.
- Ensure complainants are signposted to other agencies should they wish to pursue their complaint further as appropriate as part of the formalised response.

Where a practice is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected within six months after the report is published. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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.

- Staff were aware of how to report incidents, near misses and concerns, but evidence was not seen to suggest this was done regularly. Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated and so safety was not improved.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there was no difibrilator held on site and no risk assessment to justify this decision, despite an incident occurring within the past 18 months resulting in a patient collapsing on site.
- Reception staff were asked to perform chaperone duties without appropriate training nor appropriate Disclosure and Barring (DBS) checks being carried out.
- DBS checks that had been carried out and identified previous issues had not resulted in risk assessments being carried out to mitigate against risks posed to patients.
- There were gaps in recruitment processes; references had not been sought to confirm previous employment history and appropriate identification was not consistently checked and documented.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data showed patient outcomes were in line with averages for the locality.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was limited evidence that audit was driving improvement in performance to improve patient outcomes.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.
- There was no consent policy in place to guide staff in appropriate procedures around gaining a patient's permission to treat them.
- Staff had received appraisals, but the practice manager had yet to have training needs identified via an appraisal process.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice higher or in line with others for all aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand. While evidence showed that the practice responded quickly to issues raised, the responses produced did not include all required information, such as who to consult should the patient remain dissatisfied.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and not all were applicable to practice. There was nosystem evident to manage these documents.
- There was not an effective system in place to manage and mitigate risk to patients
- The practice had attempted to seek feedback from patients and had a patient participation group (PPG).

Summary of findings

- Staff told us they received regular appraisals. However, the practice manager had not been supported to identify training needs to develop skills in her new role.

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 provider was rated as inadequate for safety and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of older people, however;

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Flu vaccination rates for the over 65s were 74.29%, higher than the 73.24% national average.
- The practice participated in the Gold Standard Framework in order to optimise the coordination and quality of care offered to patients in the final year of their life.

People with long term conditions

Requires improvement

The provider was rated as inadequate for safety and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people, with long term conditions, however;

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- 59.6% of the practice patient population had a long-standing health condition, compared to the national average of 54%.
- Performance for diabetes related indicators was variable when compared to the national average. For example, the percentage of patients with diabetes on the register who had a record of an albumin:creatinine ratio test in the preceding 12 months was 90.48%, compared to the national average of 85.94%. The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 85.59% compared to the national average of 81.6%.However, the percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 September to 31 March was 75% compared to the national average of 93.46%.

Summary of findings

- Longer appointments and home visits were available when needed.
- All these patients were offered a structured annual review to check that their health and medicines needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The provider was rated as inadequate for safety and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of families, children and young people, however;

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice had identified 11 of its patients as children in need, and eight were on a child protection plan.
- Immunisation rates were in line with local averages for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 88.34%, which was above the national average of 81.88%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as inadequate for safety and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of working age people (including those recently retired and students), however;

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- The practice was proactive in offering online services.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as inadequate for safety and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable , however;

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- It offered longer appointments for people with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- It had told vulnerable patients about how to access various support groups and voluntary organisations.

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

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as inadequate for safety and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia), however;

- 93.33% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, compared to the national average of 83.82%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice offered an enhanced service to facilitate timely diagnosis of dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support people with mental health needs and dementia.
- The practice allowed the primary care mental health use of its facilities to offer services such as weekly Cognitive Behavioural Therapy clinics for those patients with poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015. The results showed the practice was performing either above or in line with local and national averages. There were 408 survey forms distributed and 107 were returned which gave a response rate of 26.2%. This represented 3.66% of the practice's total patient population.

- 81.2% found it easy to get through to this surgery by phone compared to a CCG average of 67.4% and a national average of 73.3%.
- 92% found the receptionists at this surgery helpful (CCG average 84.7%, national average 86.8%).
- 82.6% were able to get an appointment to see or speak to someone the last time they tried (CCG average 83.1%, national average 85.2%).
- 97.7% said the last appointment they got was convenient (CCG average 91.8%, national average 91.8%).
- 80.6% described their experience of making an appointment as good (CCG average 68.8%, national average 73.3%).
- 69.5% usually waited 15 minutes or less after their appointment time to be seen (CCG average 62.1%, national average 64.8%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards which were all positive about the standard of care received. Comments on the cards complimented staff at the practice for their professionalism and said tht GPs and nurses were empathetic and friendly.

We spoke with two patients during the inspection. Both patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. They gave particular praise for the reception staff, whom they said often went out of their way to be as helpful and supportive as possible.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Investigate safety incidents and significant events thoroughly and ensure action plans are completed and learning disseminated to staff effectively.
- Ensure a system is in place to manage, assess and mitigate risks to patients, for example those risks around medical emergencies.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there are appropriate policy documents in place to govern activity and that a system is in place to manage these documents.
- Ensure staff receive appropriate support, training and supervision to carry out their role, for example chaperoning, and that this training is managed to ensure its effectiveness.
- Ensure all clinical staff have appropriate medical indemnity insurance as required.

Action the service SHOULD take to improve

In addition the provider should:

- Ensure the infection prevention and control lead receives specific additional training to maximise the value added to this role.
- Ensure the practice manager has access to an appraisal process to identify training needs and support her in the role.
- Ensure cleaning processes are actively monitored.
- Ensure complainants are signposted to other agencies should they wish to persue their complaint further as appropriate as part of the formalised response.

Northern Moor Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor as well as a specialist advisor who was a practice manager.

Background to Northern Moor Medical Practice

Northern Moor Medical Practice is a long-established GP surgery, situated opposite Wythenshawe Park in South Manchester. There is a small car park in front of the surgery, but cars can also park on the street nearby. The premises were extended in 2011. The practice provides services to a patient list of 3132 people. The demographic area served by the practice contains a higher proportion of young people (8.4% aged 0-4, compared to the national average of 6%, 13.2% aged between 5-14 years, compared to the national average of 11.4% and 16.1% aged under 18, compared to the national average of 14.8%). The practice serves a lower proportion of over 65 year olds, just 11.1% compared to the national average of 16.7%.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice has more disability allowance claimants per 1000 (89.1) than the national average (50.3), as well as a greater proportion of its patient population with health-related problems in daily life (61.8%, compared to the national average of 48.8%). The proportion of patients who are in paid work or full time education (53.4%) is below the national average of 60.2%.

The practice is part of the NHS South Manchester Clinical Commissioning Group (CCG) and services are provided under a General Medical Services contract (GMS). There are three GP partners (two male and one female), as well as a female salaried GP. The practice also employs a female practice nurse and a health care assistant. Non-clinical staff consisted of a practice manager and five administrative and reception staff. All staff including GPs are part time. Northern Moor Medical Practice is a training practice for GP registrars and medical students.

The practice is open between 8:00am and 6:00pm Monday to Friday. Extended hours surgeries are offered between 6:30pm and 7:00pm on a Monday evening and between 7:30am and 8:00am on a Thursday morning with both the GPs and practice nurse.

When the practice is closed, patients are able to access out of hours services offered locally by the provider Go To Doc.

The practice has been inspected before on 13/02/2014 using the CQC's previous inspection methodology and was found to be compliant with the essential standards inspected against.

Why we carried out this inspection

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

Detailed findings

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. The 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.

How we carried out this inspection

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 2 December 2015. During our visit we:

- Spoke with a range of staff including two GP partners, the practice manager, the practice nurse, the heath care assistant and two receptionists / administration staff. We also spoke with patients who used the service.
- Observed how people were being cared for and talked with carers and/or family members
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care 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)

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The GPs told us there was a system in place for non clinical staff to report and record significant events, although we were unable to locate a policy documenting this procedure. Reception and administration staff told us that they were aware of this system; they told us that there was a significant event book behind reception and they knew to record events in there. However, when we viewed the book the last entry was dated 2011. When we discussed significant events with reception and nursing staff they told us that learning from significant event analysis was fed back during staff meetings. However, they were unable to describe any examples of changes to practice resulting from such analysis and feedback. Staff told us that none had been discussed in meetings recently. The staff meeting minutes we viewed did not contain evidence that significant event analysis or changes to practice as a result had been discussed.

We looked in detail at a number of significant events that had been written up by clinical staff. One was dated as occurring in September 2015 and related to personal contact details of a trainee GP being disclosed to a patient. The learning outcomes identified as a result focussed on privacy settings on social media rather than an awareness of confidentiality issues.

However we did review other significant event analysis documents relating to clinical incidents that demonstrated the practice identified shortfalls in practice and persued positive changes to procedures in order to maximise patient outcomes. For example, in response to a delay in follow up in secondary care following a patient's diagnosis of Deep Vein Thrombosis, we saw correspondence confirming that the practice highlighted action that needed to take place to avoid a repeat of the incident.

Overview of safety systems and processes

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs frequently liaised with other agencies with regard to safeguarding concerns and always provided reports where necessary for these other agencies. Staff demonstrated they understood their responsibilities and most had received training relevant to their role. GPs were trained to safeguarding level three.

However, the practice did not have clearly defined and embedded systems, processes and practices in place to keep people safe in other areas:

- Notices in the waiting room and consultation rooms advised patients that staff would act as chaperones, if required. However, not all staff who acted as chaperones were trained for the role, nor had they all received a disclosure and barring (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We spoke to two receptionists who confirmed they were asked to perform chaperone duties, but neither had received training nor had they been DBS checked. When asked they were unclear about their role and responsibilities as a chaperone and did not know where in the room they should stand in order to perform the role effectively.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A cleaner attended for seven hours per week. The practice manager showed us that the cleaner worked to a tick sheet cleaning schedule but we saw that this was not room-specific. This cleaning schedule had been introduced one month previously. No procedures were in place to monitor the standard of cleaning completed. The practice nurse was the infection control clinical lead. Although she had completed basic clinical infection control training via an e-learning package, she informed us that she had not had specific additional training to maximise the value added to this role. There was an infection control protocol in place but not all staff had received up to date training. An infection control audit had taken place and was dated 24/11/2015. This detailed an action plan but it was unclear if actions had been completed.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. We also saw logs conforming that medicines held on site were checked regularly to ensure they were in date and that there were sufficient stock

levels. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Prescription pads were stored in a lockable cabinet behind the reception desk. This was unlocked on the day of inspection, however the reception area could only be accessed by a door locked via keypad. However there were no systems in place to monitor their location or use.

- We reviewed three personnel files and found that there were gaps in the recruitment checks undertaken prior to employment. For example, there were no references stored on file for a recently recruited receptionist nor for the salaried GP. No proof of identity had been sought for the salaried GP.
- While DBS checks had been completed for some members of staff, where these had identified issues, no risk assessments had been completed to justify the decision that the candidate was suitable for the role.

Monitoring risks to patients

Risks to patients were not consistently assessed nor well managed.

- There were two health and safety policies available on the practice's shared drive; one dated as reviewed in August 2012, the other being undated. The dated policy stated that all staff should be trained in basic life support skills annually. However, the practice's training matrix indicated that staff were not up to date with this training on that basis, with three of the receptionists and the practice manager not receiving such training since October 2013. The practice had up to date fire risk assessments and carried out regular fire alarm tests. There were however no documented fire evacuation drills. There were two differing fire safety policies stored on the practice's shared computer drive, neither of which accurately reflected the actual practice. They both specified different numbers of fire extinguishers and named the practice manager as being the nominated fire warden when in fact one of the receptionists had received this training. Staff we spoke to were not able to name this receptionist as being the nominated fire warden. No other documented fire safety training had been undertaken by other members of staff. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice did have a risk assessment in place around legionella (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal), but other risk assessments were lacking.
- The practice did not have gas or electricity safety certificates available for inspectors to view during the site visit, however these were provided following the inspection.
- The GPs and health care assistant were covered by appropriate medical indemnity insurance. However, the practice nurse did not have insurance cover at the time of inspection.
- There was no system in place to monitor and ensure that clinical staff were appropriately registered with the relevant professional bodies.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and staff told us they were able to work flexibly to cover for colleague absence.

Arrangements to deal with emergencies and major incidents

The practice did not have fully adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received basic life support training, although the frequency of this training did not align with health and safety policies used by the practice. There were emergency medicines available in the treatment room.
- The practice did not have a defibrillator available on the premises, nor was there a risk assessment in place to justify the decision to not have one. In September 2014 a significant event analysis had taken place as a result of a patient collapsing on the premises. One of the learning actions identified as a result of the analysis was to review whether the practice should hold a defibrillator on site. No evidence was available to show a review had been undertaken.
- Oxygen with adult and children's masks was available. There was also a first aid kit and accident book available.

Inadequate

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice did have a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and contractors as well as alternative accommodation should the practice premises become unusable.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96.5% of the total number of points available, with 5.7% exception reporting. This practice was an outlier for one QOF clinical target. Data from 2014/15 showed;

- Performance for diabetes related indicators variable when compared to the national average. For example, the percentage of patients with diabetes on the register who had a record of an albumin:creatinine ratio test in the preceding 12 months was 90.48%, compared to the national average of 85.94%. The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 85.59% compared to the national average of 81.6%.However, the percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 September to 31 March was 75% compared to the national average of 93.46%.
- Performance for mental health related indicators was also variable when compared to the national average.For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 monthswas 89.36% compared to the national average of 86.04%.The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months (01/04/2013 to 31/04/2014) was 93.33%, compared to the national average of 83.82%.However, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 76.6% compared to the national average of 88.61%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding nine months was 150/90mmHg or less was 86.06% compared to the national average of 83.11%.

Clinical audits did not clearly show quality improvement.

- We were shown two clinical audits completed in the last two years, one of these was a completed audit where the improvements made were implemented and monitored. This audit was a self assessment checklist for cancer care. There were no documented learning outcomes or changes to be implemented following the first cycle of this audit, only after the second, therefore limiting the practice's ability to measure outcomes against changes to its own clinical practice.
- The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, GPs told us that the recent introduction of text message reminders had greatly reduced DNA (did not attend) rates.However, this was anecdotal evidence only as the practice had not quantified data around this change.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that allowed new recruits to shadow more experienced members of the team.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. The staff we spoke to and personell files we reviewed conformed that staff had received appraisals in the last year. However, the practice manager informed us that she had not yet been appraised.
- Staff received training that included: safeguarding, basic life support and equality and diversity awareness. Staff had access to and made use of e-learning training modules and in-house training. However, e-learning training documents showed that training was not being managed effectively, with staff members bypassing training content. Although they completed the online assessment component of training modules, discussion around the training content with members of the inspection team indicated that the learning objectives of the training had not been met.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services. The GPs told us that all referrals from the practice onto secondary care were peer reviewed to ensure that they were appropriate.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Staff told us that they sought patients' consent to care and treatment in line with legislation and guidance.

- Most staff understood the relevant consent and decision-making requirements of legislation and guidance. One of the GPs had recently undertaken training around the Mental Capacity Act 2005. However, while the health care assistant had also completed elearning training in this area, her understanding of the act and its implications was not thorough.
- When providing care and treatment for children and young people, staff told us that they carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- The practice did not have a consent policy available to confirm that clinicians and staff were adhereing to set protocols around obtaining a patient's consent.

Health promotion and prevention

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- The practice's uptake for the cervical screening programme was 88.34%, which was comparable to the national average of 81.88%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.
- Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 84% to 92% and five year olds from 80.4% to 100%. Flu vaccination rates for the over 65s were 74.29%, and at risk groups 49.09%. These were also in line with national averages.

Requires improvement

Are services effective?

(for example, treatment is effective)

- New patients had access to appropriate health assessments and checks. They were offered a health check on registering with the practice. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a more secluded area away from the main waiting area to discuss their needs.

All of the five patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We also spoke with two patients during the visit. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 93.9% said the GP was good at listening to them compared to the CCG average of 90.2% and national average of 88.6%.
- 96% said the GP gave them enough time (CCG average 86.9%, national average 86.6%).
- 99.4% said they had confidence and trust in the last GP they saw (CCG average 95.5%, national average 95.2%)
- 90.1% said the last GP they spoke to was good at treating them with care and concern (CCG average 85.5%, national average 85.1%).
- 95.5% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89.5%, national average 90.4%).
- 92% said they found the receptionists at the practice helpful (CCG average 84.7%, national average 86.8%)

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 87.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86.7% and national average of 86%.
- 86.5% said the last GP they saw was good at involving them in decisions about their care (CCG average 84.1% , national average 81.4%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 17.4% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them.

Good

Are services caring?

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours on a Monday evening (6:30pm until 7:00pm) and Thursday morning (7:30am until 8:00am) for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled facilities and translation services available. Longer appointments were booked if a translator was required.
- All treatment rooms were on the ground floor so access for those with mobility difficulties was facilitated.
- The practice offers a number of online services for patients including; prescription ordering and appointment booking.
- Patients could receive text message reminders for appointments if they opted in to that service.

Access to the service

The practice was open between 8:00am and 6:00pm Monday to Friday. Extended hours surgeries were offered between 6:30pm and 7:00pm on a Monday evening and between 7:30am and 8:00am on a Thursday morning with both the GPs and practice nurse. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. On the day of inspection there remained prebookable appointments available the following day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages. People told us on the day that they were were able to get appointments when they needed them.

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 72.7% and national average of 74.9%.
- 81.2% patients said they could get through easily to the surgery by phone (CCG average 67.4%, national average 73.3%).
- 80.6% patients described their experience of making an appointment as good (CCG average 68.8%, national average 73.3%).
- 69.5% patients said they usually waited 15 minutes or less after their appointment time (CCG average 61.2%, national average 64.8%).

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The practice leaflet contained information about how to complain if patients were dissatisfied with the service they received.

We looked at two complaints received in the last 12 months and found that these were dealt with in a timely manner with a written response offering an apology as appropriate. However the responses did not signpost the complainants to the Parliamentary Health Service Ombudsman should they be unhappy with the outcome of the investigation. Staff were unable to describe what lessons were learnt from concerns and complaints when asked.

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 had a vision to deliver high quality care and promote good outcomes for patients.

- The GPs told us that where possible they aligned their own personal development objectives with colleagues so as to maximise the skill mix and clinical experience available in the practice.
- The partners had acknowledged the benefit of having a pharmacist available as part of the practice team and planned to recruit one to the practice in the near future.

Governance arrangements

The practice lacked a clear overarching governance framework to support the delivery of the strategy and ensure consistent good quality care. While there were policies and procedure documents available on the shared computer drive, these lacked organisation or management. There were duplicated documents and there was no system in place to monitor the review and update of documents in use. Not all policies were dated or had been reviewed and not all were applicable to practice; for example the health and safety policy was dated as having been reviewed in August 2012. There was no date for next review included in the document. Neither of the fire safety policy documents listed the correct number of fire extinguishers on the premises. The recruitment policy document lacked sufficient detail around the recruitment procedure that needed to be followed when employing new staff.

While some audit was carried out, a system to manage audits undertaken was not evident to ensure that audit cycles were repeated when necessary to maximise learning and improve patient outcomes.

Aarrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not in place. Staff training in the practice was not being effectively monitored or managed.

Staff told us there was a clear staffing structure and that members of the team were aware of their own roles and responsibilities

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

The practice manager had been in post since March 2015, having previously worked as a receptionist at the practice. She had not yet been offered an appraisal to identify her training needs.

The partners told us that they encouraged a culture of openness and honesty. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice held regular team meetings. We saw minutes confirming they were held on a monthly basis.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had attempted to gather feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was a PPG, although the GPs told us interaction with the 24 membeers was via email rather than face to face. The GPs confirmed that they had limited interaction with the PPG.
- The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff

Are services well-led?

Requires improvement

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

told us 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 to improve how the practice was run.

Continuous improvement

There was a commitment to learning and improvement, however there were gaps in the application of processes to achieve this.

The practice team had been recognised for their work supporting trainee GPs, having been awarded a Quality Teaching Practice Gold award for 2014/15.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes had not been established to identify, assess, monitor or manage risk to patients or staff. There was not an appropriate range of policy documents in place to govern activity nor a system is in place to manage these documents. Regulation 17 (1) a, b, d

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff training was not managed in such a way as to ensure appropriate training and professional development was carried out to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) a

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.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to the health and safety of service users receiving the care or treatment were not assessed, nor was action taken to mitigate these risks Regulation 12 (1), (2) a, b, d, f, g

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Appropriate recruitment checks were not consistently carried out prior to the employment of staff. There was no system in place to monitor and ensure that clinical staff were appropriately registered with the relevant professional bodies. DBS checks that had been carried out and identified previous issues had not resulted in risk assessments being carried out to mitigate against risks posed to patients. Regulation 19 (1) a, b, (2) a, (3) a, b, (4) a, b