Newport Medical Group

Quality Report

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Date of inspection visit: 25 March and 29 April 2015
Date of publication: 27/08/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 25 March and 29 April as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be rated as good in providing, effective, caring, responsive and well-led services. However, we have found the practice to require improvement in respect of providing safe care. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Incidents were being reported and learning shared with staff. However, directives for nurses to administer medicines were not current
- Patient care was provided by staff who had received appropriate training. The practice worked with other health and care providers to deliver co-ordinated care.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.
- The practice had appropriate skill mix of staff team with expertise and experience in a range of health conditions.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

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

Importantly, the provider must:

Summary of findings

- Must ensure medicine directives are current and within guidance.

In addition the provider should:

- Ensure patients are made aware when appointments are booked with the advanced nurse practitioner and not a GP.
- Ensure a consistent approach is followed when staff carry out the role of a chaperone.
- Ensure systems are in place to monitor if cleaning is being done according to standards set by the practice.
- Ensure all audits are dated and action identified and followed up.
- Ensure action actions recognised following legionella risk assessment are being implemented.
- Ensure staff are enabled to fulfil their roles adequately
- Review the complaint policy and ensure appropriate mechanisms in place to action complaints when the lead is on leave.
- Ensure the whistle blowing policy is reviewed to include third party contact details.

Ensure the practice responds to any recommendations arising out of the referral to the local authority safeguarding team for circumcision practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Risks to patients were assessed and but were not always well managed for example legionella. Reliable systems had been arranged for the safe storage of medicines and vaccines within the practice. The practice did not have up to date medicine directives for the safe use of medicines. On one occasion we saw that one of the vaccine fridges was being used for the storage of other items in addition to medicines. There was a designated lead to oversee the hygiene standards within the practice to prevent infections. However, there were no processes in place to ensure cleaning was being done to appropriate standards.

Are services effective?

Good

The practice is rated as good for providing effective services. Clinicians worked to the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Patients' needs were assessed and care planned and delivered in line with current legislation. Clinicians had carried out clinical audits and made changes where necessary to promote effective treatments for patients. Systems were in place for regular reviews of patients who had long term conditions, those identified as at risk and housebound patients. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could show that appraisals and the personal development plans had been completed for all staff files we looked at. Records looked at showed that the practice worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services was available and easy to understand. Staff treated patients with kindness and respect and maintained confidentiality. We observed staff interacting with patients in a caring and supportive way. We saw that staff were able to communicate with patients in a language they understood. Accessible information was provided to help patients understand the care that was available to them.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us they could get an appointment with the GP or an advanced nurse practitioner. However, patients told us that at times appointments were booked with the advanced nurse practitioner and not with a GP, and they were not informed of this. Patients had access to screening services to detect and monitor certain long term conditions. There were immunisation clinics for babies and children. If patients were unable to attend the practice a home visit could be arranged. The practice had a system in place to respond to complaints and concerns but needed to review its complaints policy.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear statement of aims and objectives and we saw examples where the practice worked together to implement this. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered personalised care to meet the needs of its population. All elderly patients above the age of 75 have a named accountable GP to co-ordinate care and services using a multi-disciplinary approach. The practice participated in a national immunisation programme to vaccinate patients aged 70 and 79 against shingles. Patients at risk of an unplanned hospital admission had a care plan in place, which was regularly reviewed and updated. Housebound patients were visited so they could be given information and advice to prevent hospital admissions. The wishes of patients requiring end of life care were met by the GPs and multi-disciplinary team. Telephone consultations were available so patients could call and speak with a GP if they did not wish to or were unable to attend the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than average number of patients with diabetes. The practice had employed a specialist diabetes nurse and held specific clinics for patients with diabetes. The practice also employed advanced nurse practitioners trained to manage common medical problems. They were able to offer enhanced diagnostic services for chronic disease management such as spirometry for asthma. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed for patients with long term conditions. Practice staff held a register of patients who had long term conditions and carried out regular reviews. There was a recall system in place when patients failed to attend for their reviews. For patients with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Milestones were assessed as per the child health surveillance programme. 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. Practice staff liaised with local health visitors who were located within the main site (Sparkbrook

Summary of findings

Health Centre) to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The practice nurse offered immunisations to children in line with the national immunisation programme.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice offered patients extended appointments three times a week to meet the needs of this population group. Appointments were available on any of the three sites if it was convenient for the patient. Telephone appointments were offered for patients unable to attend due to work with a convenient follow up appointment if needed. Online booking of appointments and ordering of prescriptions were not available. However, arrangements were being made so that the needs of those patients who worked could be met through online appointments and repeat prescriptions. The practice offered a range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 to 70 years of age.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up where issues were identified. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out regular home visits to patients who were housebound and to other patients on the day they had been requested. Vulnerable patients such as those without a fixed above were able to register at the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. The practice offered health checks to patients on the mental health register. Practice staff worked in conjunction with the local mental health

team to ensure patients had the support they needed. GPs had the necessary skills and information to assess and treat or refer patients with poor mental health including training in the Mental Capacity Act 2005 to ensure all care provided was in patient's best interests.

Summary of findings

What people who use the service say

We carried out an inspection of this site on 25 March and 29 April 2015 and spoke with five patients. One of the patients we spoke with told us that they always received a good service and were positive about the GPs and staff. They also stated that they often had to wait over an hour after their appointment time with the average wait time to be seen of between 20 and 40 minutes. Four of the patients also stated that they often had to wait a long time to be seen after their appointment time. They stated that often a GP was not available and reception staff would book consultations with the advanced nurse practitioner. Two patients had not realised that they had a consultation with the advanced nurse practitioner as they thought they had booked an appointment with a GP.

We collected 35 Care Quality Commission comment cards from a box left in the practice two weeks before our visit at the Sparkbrook site. Feedback from patients was overall positive. Five of the comments cards were positive about the staff and the new surgery building but also stated they found it hard to get through to the practice by phone or get an appointment when needed. The other 30 comments cards were positive about the practice and staff.

We looked at the national GP patient survey published in January 2015 which reflected all three sites. When patients were asked "Overall, how would you describe your experience of your GP surgery" 56% responded very good or fairly good. This placed Newport Medical Group in the bottom 10% of GP practices nationally. However, 459 surveys were sent and only 16% of those issued were returned. Of those responding 91% had confidence and trust in the last GP they saw or spoke to, this was slightly lower than the Clinical Commissioning Group (CCG) average of 93%. Eighty-three percent of respondents had confidence and trust in the last nurse they saw or spoke to. This was lower than the CCG average was 95%.

Newport Medical Group had also undertaken its own patient satisfaction survey for the 2014-15. Results showed that 98% of patients surveyed were positive about the overall performance of the GPs and 97 for the nurses. Ninety-six percent of patients felt involved in the decisions about their health and 95% stated that they would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure medicine directives are in date.

Action the service SHOULD take to improve

- Ensure patients are made aware when appointments are booked with the advanced nurse practitioner and not a GP.
- Ensure a consistent approach is followed when staff carry out the role of a chaperone.
- Ensure systems are in place to monitor if cleaning by cleaners is being done according to standards set by the practice.
- Ensure all audits are dated and action identified and followed up.
- Ensure action actions recognised following legionella risk assessment are being implemented.
- Ensure staff are enabled to fulfil their roles adequately
- Review the complaint policy and ensure appropriate mechanisms in place to action complaints when the lead is on leave.
- Ensure the whistle blowing policy is reviewed to include third party contact details.
- Ensure the practice responds to any recommendations arising out of the referral to the local authority safeguarding team for circumcision practice.

Newport Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team on 25 March was led by a CQC Lead Inspector. The team included a GP specialist advisor, a CQC inspection manager, a practice nurse specialist advisor and a practice manager specialist advisor. On 29 April 2015 our inspection team consisted of a CQC inspector only.

Background to Newport Medical Group

Newport Medical Group has practices registered with the Care Quality Commission at three locations; Sparkbrook Health and Community Centre, Newport Road and Stoney Lane. The practice list size for Newport Medical Group is approximately 10.500 patients. Patients are able to visit any of the three practices in order to access primary medical services.

The staff group, policies, systems and procedures at Newport Medical Group are centrally managed and are reflective across all three registered practices. We inspected the main site at Sparkbrook health Centre (34 Grantham Road) on 25 March 2015. We also visited the other two sites at Stoney Lane and Newport Road. On 29 April 2015 made further a visit to both the Stoney Lane site and Newport Road site to gather more information.

All three practices are registered individually with CQC and therefore, each site has an individual report and rating. However as the practice has one General Medical Services (GMS) contract, patient list and clinical data system with a shared staff group, the data included in this report reflects all three practices.

There are six GPs (one female, five male) and most GPs work across all three sites. The partnership consists of two GP partners, three salaried GPs and a regular locum GP. There are three advanced nurse practitioners and three practice nurses. The practice manager, who is one of the nurse practitioners, is supported by an administration team, who also, when required, works across the three sites.

The practice does not provide an out-of-hours service to patients but has alternative arrangements in place for patients to be seen when the practice is closed. For example, the practice telephone answer machine and the website advises patients with severe chest pain, loss of blood, suspected stroke or suspected broken bones to call 999 and ask for an ambulance. Patients are advised to contact NHS 111 or Badger (Birmingham And District General Practitioner Emergency Room) when the surgery is closed and in the event they need to speak with a doctor urgently. Alternatively, patients can visit the walk in centre at The Hill General Practice and Urgent Care Centre, 856 Stratford Road, Sparkhill open from 8am to 8pm, seven days per week.

One of the GP partner runs a circumcision clinic from this site and the related out of hours service is provided by the GP.

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

Detailed findings

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?
- 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 inspecting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 25 March and 29 April 2015. During our visit we spoke with a range of clinical and non-clinical staff and spoke with patients who used the service. We observed how people were being cared for and talked with patients and family members.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We saw there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

The practice held regular practice meetings which included a review of the practice's safety record. We saw records of incidents and minutes of meetings where they were investigated. Where action had been required, systems had been put in place to address them.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of 26 incidents that had been recorded from June 2013 to February 2015. We saw that they had been reviewed for any themes or emerging trends. Staff members we spoke with told us that significant events were discussed in meetings. We saw minutes of meetings where significant events were a standing item on the meeting agenda and they were held weekly. We saw an example of a significant event that was discussed at the clinical meeting in January 2015. This related to a delay in issuing of death certificate. The practice had taken action by assigning a task to a staff member to develop a protocol to minimise delays and ensure all staff were aware of the procedure to follow.

There was evidence that the practice had learned from investigations and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw evidence that the practice responded to national patient safety alerts. We saw an example of a safety alert that was received by the practice. We saw that the alert was cascaded to all clinical staff and action taken had been documented.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff members we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours if they had any concerns. Contact details for the relevant agencies in working hours and out of normal hours were easily accessible.

The practice had appointed dedicated GP as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of the lead and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example we saw alerts on the computer system for children subject to child protection plans as well as adults subject to domestic abuse. We saw safeguarding was a standing item on minutes of meetings. We saw examples where safeguarding issues were discussed with actions where appropriate.

The practice undertook circumcision procedures for boys under one year of age. We asked the nurse how the procedure was completed to ensure the child remained safe throughout. They explained the use of a moulded circumcision restraint board with a restraint policy in place to support this. From our discussion with the nurse it was clear that the child's welfare and safety had been considered. In order to ensure that the arrangements in place were the safest and most appropriate, so as not to

cause undue distress to children undergoing the procedure, we raised this matter to the local safeguarding team. We have also informed other key stakeholders such as NHS England local area team and the Clinical Commissioning Group (CCG).

There was a chaperone policy in place. Details of the chaperone process were included in the practice leaflet and displayed in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. This was also confirmed by patients we spoke with. Some patients also told us that chaperones also stood outside of the privacy curtains when clinical staff were undertaking procedures inside the privacy curtain. This was also confirmed by some staff members we spoke with. We spoke with the lead GP who told us that chaperones generally stay inside the curtains unless specifically requested by patients to stay outside. We spoke with another staff member who told us that they normally stood inside the curtains as that was the correct procedure. However, some patients would ask them to be outside especially if the patient and the chaperone were of the opposite gender. We looked at the chaperone policy which stated that staff undertaking the role of a chaperone could stand outside of the curtain if asked by the patient. This would not enable the chaperone to observe the procedure so as to be a reliable witness about what happened. The policy did not include offering the patient another appointment with a same sex clinician or chaperone.

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. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

However, on our inspection to this site on 25 March 2015 we found that food was being kept in the medicine fridge. We spoke with staff regarding this and acknowledged that this should not have happened. We looked at the medicine fridge again on our second visit on 29 April and we did not see this again and a staff member we spoke with assured us that system were in pace to ensure this never happened again.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. However, we saw that these directives were not up-to-date. Patient group directives provide a legal framework for the administration of medicines by a range of qualified healthcare professionals including nurses.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We saw alerts on medical records for when a medical review was due for medicines. GPs we spoke with told us and we saw that certain medicines were never put on repeat script for more than 28 days.

The GPs we spoke with told us that they had established a repeat prescribing system and had reviewed all patients on repeat prescriptions. These changes were then discussed at clinical meetings which had resulted in the employment of a practice pharmacist who also worked for the Clinical Commissioning Group (CCG). They told us that the pharmacist had introduced good practice in regards to prescribing medication audits which allowed them to meet their prescribing targets. The lead GP we spoke with told us, and we saw prescribing data which was based on the RAG status (traffic light system) and showed that practice was on amber zone for prescribing laxatives, sip feeds and some antibiotics. The practice was under prescribing for other antibiotics which showed that it was meeting and exceeding local targets.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had contract cleaners coming to the practice daily. We saw cleaning schedules were in place however cleaning records were not kept. There was no system for auditing and monitoring the quality or effectiveness of the cleaning. Staff members we spoke with told us that they monitored this through general observation. We discussed this with an infection control lead who recognised the need to review this.

Requires improvement

Are services safe?

We saw that the Clinical Commissioning Group (CCG) had completed an infection control audit in September 2013. Actions arising from the audit had been completed. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw that the practice had carried out their own infection control audit of the building. The infection control lead told us that audits were scheduled to be completed three monthly. The information contained in the audit was minimal and did not identify individual treatment and clinical rooms.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks were available with hand soap, hand gel and hand towel dispensers. Staff members we spoke with were aware of basic hand washing technique. We saw that a hand hygiene audit report for all three sites which stated that there was a 91% compliance overall. We saw that learning had been identified and appropriate action taken.

The practice had a lead for infection control who had undertaken recent further training. Staff members we spoke with were aware of the lead. Staff members we spoke with told that that they had online infection control training and weekly team meetings were used to share any updates by the infection control lead. Staff told us that they were aware of the practice nurse undertaking regular infection control audits. We saw that an up to date infection control policy was available containing information relating to spillages, needle stick injuries as well as disposal of bodily fluids. We saw that there was a spillage kit available for bloods, urine and bile and was in date.

We saw that an infection control audit had been carried out in March 2014 and issues identified were actioned. The practice had conducted a legionella (a term for particular bacteria which can contaminate water systems in buildings.) risk assessment in September 2014. However, the practice had not received the report back until March 2015. We saw that actions identified in the risk assessment were being followed.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested with a schedule of testing in place. We saw evidence that calibration of relevant equipment; for example weighing scales had been scheduled for an annual check.

Staffing and recruitment

The majority of staff worked across all three sites, when necessary. Recruitment files were held centrally and the practice had dedicated human resources personnel responsible for managing this. The practice also had a contract with an external company to provide recruitment advice and guidance.

At our previous inspection in August 2014 we found that there were incomplete recruitment records. There were gaps in the documentation for example, there was no evidence that qualifications had been verified, references sought, and employment history checked. At this inspection we were told that the practice had updated all staff details so that all recruitment information was available.

During the inspection we looked at a selection of staff files including those staff that had been recruited since the last inspection in August 2014. We found recruitment records 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). The practice had a recruitment policy and had developed a checklist that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. GPs, practice nurses and administration staff were based at each of the three locations. All of the staff we asked said that they worked across all locations when necessary to support the smooth running of the practices. For example, a GP was always scheduled for administrative tasks and if there was a shortage of a GP for patient appointments due to unexpected absence, for example, the GP scheduled for administration duties would be available to cover. A staff member responsible for human resources told us that

there were always two reception staff, two administration (back room) staff and a line manager within the reception team on duty. We saw sufficient staffing levels in place during our inspections.

Patients we spoke with tod us that they often had to wait a long time to be seen by a GP and at times they were advised to attend the walk in centre. When we visited this site on 29 April we saw that there was one GP in the practice. There was also an advanced nurse practitioner available for consultation. We saw that most patients were seen by the advanced nurse practitioner and the GP was running the circumcision clinic.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw that the practice had a health and safety policy and had completed a health and safety risk assessment check list. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

Emergency medicines were available in a secure area of the practice and the staff we asked knew of their location. These included those for the treatment for cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED, used to attempt to restart a person's heart in an emergency). The practice was responsible for the maintenance of the equipment and we saw evidence of regular checks that were in place. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We saw a significant event analysis where a new GP at the practice recognised that management of emergency medicines were not robust during a consultation with a patient. This was discussed with the practice team and the responsibility was assigned to a staff member to refer to appropriate guidance to develop a robust system for management medical emergencies. We saw a review of the action undertaken in January 2015. This noted that a new emergency medicine bag and a locum GP pack were put in place. The staff induction pack was also reviewed as part of the practice's medical emergency review, and the location of the emergency medicines were included in the induction pack so that all new and existing staff were aware. We also saw that this was scheduled for further review in June 2015 to ensure this was being managed appropriately.

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). We spoke with the lead GP who told us that they had discussed NICE guidance on atrial fibrillation (a heart condition). We saw updated guidance was available for the management of atrial fibrillation in the practice. We saw minutes of practice meetings where new updates and NICE guidelines were discussed and disseminated. For example, in one of the clinical meetings in January 2015 we saw that a GP presented an article on a disease together with risk factors, treatment and referral strategies with key points for discussion.

One of the GPs we spoke with told us that they were the lead for diabetes care and, at the time of our inspection, were finishing their diploma. They also told us that they were also the lead at the practice for joint injections. The practice also had a specialist diabetic nurse which allowed the practice to focus on diabetes as there was a high prevalence of diabetes within the patient population. There were also GP leads for sexual and reproductive care, palliative care and child health. There was a nurse lead for travel and childhood immunisation.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. For example, a GP we spoke with told us that female GPs at the practice usually undertook assessments such as breast examinations.

We saw data from the local Clinical Commission Group (CCG) of the practice's performance for prescribing, which predicted a slight overspend for the year. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The practice was aware of its prescribing performance and had employed a prescribing support pharmacist who also worked for the CCG. The GPs we spoke with told us that they were helping to reduce some of their prescribing to meet the local CCG aspirational targets.

The GP we spoke with told us that they were similar compared with other practices in the local area for referrals to secondary care. The latest data we looked at showed that the referral rates for the practice were generally similar to the local CCG average.

Management, monitoring and improving outcomes for people

The practice responded to risk by communicating with external organisation and internally with staff members. We were told about an event where the practice identified the outbreak of a virus in two patients from the same area. The lead clinician told us that they had spoken verbally with partners to be aware of any patients attending from the same area. Also, we saw an example of screen messages that were sent to all clinicians to make them aware.

The practice had a system in place for completing clinical audit cycles. The practice showed us five clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit was conducted to assess the uptake of pneumonia vaccine between 1 November 2014 and 1 February 2015 for patients aged over 65. It was found that 10% of eligible patients were immunised which was well below the Department of Health (DOH) guidelines. Reasons for this was recognised and discussed and an action plan as put in place. A re-audit was carried out after two months and the uptake was at 28%. The practice had made further changes to improve this and a re-audit was rescheduled in six months. We also saw that the practice had conducted a minor surgery audit with actions identified. However, these audits were not dated and dates for actions to be completed were not scheduled.

Another example of a clinical audit was linked to medicines management information. We saw that the practice was an over prescriber for laxatives and an audit was carried out by the practice looking at the prescribing of laxatives. In total 20 patients on regular prescribed laxatives were

identified in the audit. Their medical notes were reviewed and repeat prescribing records were reviewed and seven patients were identified where current laxative use was not appropriate. We saw appropriate action was then taken.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The lead GP we spoke with told us that they carried out annual appraisals for clinical staff. The senior nurse was responsible for supervising practice nurses. Minutes of clinical meeting we looked at showed that staff discussed and presented updates to clinical practice and where this could be improved.

There was a protocol for repeat prescribing which was in line with national guidance. The GPs we spoke with told us and we saw that alerts for medicine reviews were put on medical records. Other medicines such as antidepressants were not given for more than 28 days. The practice pharmacist also looked at medicine reviews and monitored the repeat prescribing system. This enabled the practice to provide treatment based on the needs of the patient.

The practice had implemented the gold standards framework for end of life care. There was a protocol for end life so that supportive and optimal care could be provided. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a palliative care lead at the practice who had undertaken appropriate training.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. There were two GP leads at the practice for minor surgery and joint injections. One of leads we spoke with showed us an example of a consent form for steroid joint and tissue injection. The form had pre populated discussion points around the procedure along with risks. The GP told us that they discussed the procedure with patients so that they could make an informed decision.

The practice also participated in local benchmarking run by the CCG. The practice was part of a CCG peer review group. The lead GP we spoke with told us that they had discussed the practice referral rates and prescribing data. The referral rate was average in comparison to the local rate and the practice was slightly above average for prescribing. The practice was working with the practice pharmacist to review its prescribing.

The lead GP performed circumcision for boys aged below 12 months. The practice had a follow up procedure to review any complication. Patients' relatives were called 24 hours after the procedure and asked if there were any issues or complications. Patients' relatives were advised on what to expect after one week of the procedure. They were asked to come back if things did not go as expected. We saw evidence on our inspection visit that patients were seen after a week of the procedure if needed. If patients relatives did not call it was assumed that there were no complications.

We saw that a minor surgery (circumcision) audit had been carried out. This detailed the number of circumcisions performed, the number of post-operative reviews and possible complications. However, the follow up process did not support a full audit process to ensure any relevant changes were identified to improve outcomes for patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with one GP completing a diploma in diabetes and attending further training in sexual health. The practice recognised that there was a higher prevalence of diabetes amongst the patient population and had recently hired an additional nurse practitioner who was a diabetes specialist nurse.

Relevant staff files we looked at showed that they were up to date with their yearly continuing professional development requirements and all GPs 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff files we looked at and staff we spoke with confirmed that the practice was proactive in providing training for relevant courses. For example, a GP at the practice was helped to attend various courses including a palliative care and sexual health course. Other staff members had access

Good

Are services effective?

(for example, treatment is effective)

to various online training such as equality and diversity, infection control, fire safety as well as role specific training such as information governance training for medical secretaries.

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 both electronically and by post.

The practice manager told us that discharge letters from hospital as well as faxes from out of hours services were reviewed by GPs and stamped with the action required. These were then given back to reception staff to action such as making follow up appointments or referrals. They were then scanned to patient records. The GPs and other staff we spoke with also confirmed that this was the process for managing communication from other services.

The practice was commissioned for the new enhanced service 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). We saw that the policy for actioning hospital communications was working well in this respect. We saw that unplanned admission was a standing item in the weekly clinical meetings and any issues identified were assigned a lead to action.

A GP at the practice told us of the good working relationship they had with community services, for example the health visiting team, district nurses, midwives and the palliative care team. The practice held multidisciplinary team meetings monthly to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. We saw minutes of meetings and the GPs and staff we spoke with also confirmed this. These meetings were attended by district nurses, community development workers, health visitors and palliative care nurses. Decisions about care planning were documented in a shared care record. One of the GPs we spoke with told us that this was an area they had worked on over the last six months to improve.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used Choose and book to make referrals to specialist care. 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. We were told and the latest information we looked at showed that the practice referral rate was similar to the local CCG average. We saw that referrals were discussed in clinical meetings to optimise patients care.

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. The practice manager we spoke with told us that the practice administration staff were multi-skilled to use the systems. 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

There was a practice policy in relation to consent. Minor surgery was carried out at the practice. Clinical staff we spoke with described the consent process prior to minor surgery being undertaken. We saw a consent forms were in place.

One of the GP partners carried out circumcisions for children under 12 months of age. We saw that that there was a restraint in circumcision policy in place. The policy stated that the doctor would restrain the legs of a child during administration of the local anaesthetic. After the local anaesthetic is applied the arms and legs would be restrained with crepe bandages. The policy also stated that they would not allow any form of restrain for any child above 12 months.

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation. MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff we spoke with demonstrated understanding of Gillick competency. Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Good

Are services effective?

(for example, treatment is effective)

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 GP was informed of all health concerns detected and these were followed up in a timely way. The practice had a wide range of health promotion leaflets and self-help guides in the surgery and on their website. The practice also offered NHS Health Checks to all its patients aged 40 to 70 years. The practice informed us that they had carried out health checks for 4% of this group. The practice also offered chlamydia screening to patients aged 18 to 25 years and 1% had been screened so far this year.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. There were 33 patients on the register and 52% had had a health care review over the last 12 months. The practice had reviewed 94% of patients with Chronic Obstructive Pulmonary Disease (or COPD) this year. COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath; persistent cough and frequent chest infections. Seventy-two percent of patients with asthma had had an annual review while 80% with cardiovascular disease (CVD) had had a review. Seventy-five percent of patients with diabetes had had a review. All patients over 75 years of age had a named accountable GP to co-ordinate care and the practice took part in a national immunisation programme to vaccinate patients aged 70 to 79 against shingles (inflammation of the skin around the middle part of the body).

There was evidence of specialist clinics to review patients with long term conditions. This included a dedicated diabetes clinic, asthma clinics as well as other clinics such as coronary heart disease.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The lead GP we spoke with told us that they had performed well in regards to immunisations and had met their targets.

The practice took part in the health exchange programme to reduce the incidence of diabetes. It recognised that majority of the patient population was comprised of black and ethnic minority (BME) groups who had a higher prevalence of diabetes. The health exchange is a patient education programme intended to reduce the diagnosis of Type 2 diabetes working closely with CCGs.

The practice website provided handy advice for parents with young children and there was a link to a handbook from Sandwell and West Birmingham CCG titled ‘A Guide for Parents and Carers of children from 0-5 years’. This handbook gives some helpful advice on common childhood illnesses.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 which sent out 450 surveys. Twenty-one percent (94) of the surveys were returned. The evidence from this showed that 92% of respondents said the last appointment they got was convenient compared to the local Clinical Commissioning Group (CCG) average of 90%. One of the GP's we spoke with told us that they had been working to improve access to the surgery. Eighty-eight percent said the last nurse they saw or spoke to was good at treating them with care and concern. However, this was lower at 65% for the GPs. This was slightly better than the local CCG average. The practice had conducted its own survey more recently which showed that 95% of those surveyed would recommend the surgery.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said the staff were very friendly, sympathetic and helpful. They felt that the reception staff were accommodating, respectful and caring. One patient we spoke with told us that their experience with staff was negative when they had joined the practice two years previously. However, this had gotten better as staff were more sympathetic to them and were more helpful because they had understood the patients' unique circumstances.

Five comments cards were positive about the staff and the level of care received but stated that they found it difficult to get through on the phone in the mornings and some stated that the waiting time to be seen were often longer than 15 minutes. We spoke with five patients on the day of the inspection. Most patients stated that they could get an appointment if needed but at times the wait to be seen was on average between 20 and 40 minutes.

Staff members we spoke with were aware of issues relating to confidentiality and information governance. Records we looked at showed that staff had received information governance training and staff also told us that they had signed a confidentiality statement as part of their contract. Staff told us that they tried to observe confidentiality in the reception area and were mindful of being overheard when they spoke with patients at the reception desk.

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

Care planning and involvement in decisions about care and treatment

The practice had carried out a patient survey for 2014-15. The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, we saw that 95% of the patients surveyed stated that they would recommend the practice. Patients also rated the overall performance for GPs and nurses at 98% and 97% respectively. There was positive feedback regarding access to appointments and 96% respondents were satisfied that they were involved in the decisions about their health care.

We saw that the national GP patient survey did not completely reflect this as 54% of respondents stated they would recommend this surgery to someone new to the area. Fifty-seven percent of respondents stated the last GP they saw or spoke to was good at involving them in decisions about their care. We spoke with staff regarding this and they told us that the practice had recruited two new GPs and two new reception staff while another GP was being recruited. We were told that the practice had relied on locum GPs before the recruitment of new permanent GPs. Patients we spoke with on the day told us GPs explained things to them in way they understood and spent enough time with them. Some commented that the GPs were busy as there was a high demand for appointments.

Patient/carer support to cope emotionally with care and treatment

Comment cards completed by patients were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided

Good

Are services caring?

support when required. A patient we spoke with on the day told us that when staff at the practice had become aware of their circumstances they were more understanding of them and their family, and were very friendly and caring.

Notices and leaflets in the patient waiting room and the practice website also 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 website encouraged people to inform them if they were carers so they could help where appropriate. We saw information available for carers to ensure they understood the various avenues of support available to them.

We saw that regular multi-agency meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives or carers in the waiting rooms on the practice noticeboard. The practice manager and the GPs we spoke with informed us the respective GP contacted bereaved families and went out to visit them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

As part of our inspection of the Newport Medical Group we visited Stoney Lane Surgery on 29 April 2015. On this visit we found that there was one GP on site and an advanced nurse practitioner was available for consultation. Reception staff we spoke with told us that the GP held clinics for circumcision and most consultations were being held by the advanced nurse practitioner. We spoke with five patients on the day and four of the patients told us that consultations were usually booked with an advanced nurse practitioner without informing them. One patient told us that they had raised this several times but they were still being booked with the advanced nurse practitioner under the 'pretence' of seeing a GP. Another patient we spoke with told us that they had two previous consultations with the nurse and had not realised this. We spoke with the reception staff who told us that they informed patients when they were booking patients with the nurse. However, we observed a patient refer to the advanced nurse practitioner as the 'doctor' and reception staff made no attempt to correct them. We looked on the practice website which made clear the role of the nurse practitioner. It also stated that they were available for appointments and they specialised in triage.

We found some of the needs of the practice population were understood and systems were in place to address these needs. For example, the practice had recognised that there was a high prevalence for diabetes and had employed a diabetes nurse specialist. A GP was undertaking a diploma in diabetes and both the GP and the nurse were the leads in the practice responsible for managing this patient group. Staff we spoke with displayed an understanding of cultural diversity and needs of the local population and some spoke other languages spoken by patients.

The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

The practice had a register of patients who had mental health needs and we saw that annual health checks had been carried out. The practice had a palliative care register and regular multidisciplinary meetings were held to discuss patients and their families care and support needs. Minutes of meetings we looked at confirmed this.

The practice had a Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with three members of the PPG on the day of the inspection including the chairperson. They told us that access to appointments and car parking was an issue. We saw minutes of PPG meetings where this was discussed and various options for improvement considered. For example, the PPG were informed that more staff members were recruited and were due to start working at the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. A GP gave us an example of a patient who lived alone with little support and limited English. The GP recognised not only the health needs of that patient but also how their condition affected their spiritual wellbeing. They told us of the care and treatment they had provided which was respectful and empathetic to the patients health and cultural beliefs.

The practice removed barriers some patients faced in accessing or using the service. A female GP worked at the practice and was able to support patients who preferred to have a female doctor. They were also the lead for sexual and reproductive care within the practice and this helped to reduce any barriers to care and supported the diverse needs of the patients.

The GPs, nurse and administration staff spoke a number of languages. We saw that there was the facility to translate the practice website into over 90 different languages.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, there was ramped access and there was a call bell on the door so that patients with a disability

Good

Are services responsive to people's needs?

(for example, to feedback?)

could be helped to enter the practice. We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available to them should they need it. One patient told us how their GP was able to provide them with telephone consultations during their pregnancy, the patient had difficulty in getting to the practice and the GP supported the patient by suggesting that consultations were provided over the phone. Staff told us that translation services were available for patients who did not have English as a first language.

The practice provided equality and diversity training through e-learning. Staff files we looked at confirmed that they had completed the equality and diversity training in the last 12 months. Staff members we spoke with also confirmed this.

Access to the service

Information was available to patients about appointments on the practice leaflet and through their website. This included details on how to arrange home visits. The practice provided out-of-hours service for circumcision only. For other patients, alternative arrangements were in place so that they could be seen when the practice was closed. For example, the practice telephone answer machine and the website advised patients with severe chest pain, loss of blood, suspected stroke or suspected broken bones to call 999 and ask for an ambulance. Patients were advised to contact NHS 111 in the event they needed urgent advice. Alternatively, patients could visit the walk in centre nearby (**Sparkhill Primary Care Centre),** open from 8.00am to 8.00pm, seven days per week.

Patients confirmed on the comment cards that they were always able to see a GP on the same day if they needed to. We spoke with one patient who had been given an urgent appointment. Almost all the patients we spoke with also confirmed that they could get an appointment in an emergency although one patient stated that they were encouraged to go to the walk in centre if there was no appointment available. The practice survey showed that 60% of patients said they were able to get an appointment on the same day or the next day. This was 87% for appointments within three days. Most patients we spoke with also stated that they had to wait on average of between 20 and 40 minutes after their stated appointment time, to be seen.

Longer appointments were available for patients who needed them including those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who could not attend the practice. We spoke with the lead GP who told us that they made seven home visits a week on average and as a practice they made 30 to 40 home visits weekly.

Telephone appointments were available if a patient could not come in to the practice with a follow up appointment if needed. Extended hours appointments were available for patients three times a week at any of the three registered practices. This was useful for working age patients who did not have to take time off work to attend.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Details of the complaints process were available on the practice website, practice leaflet and displayed in the waiting area of the practice. We noted that the information in the practice leaflet did not reflect the current external complaints process and needed to be amended. Patients wishing to raise a complaint were advised to obtain a complaints form from reception. Reception staff we spoke with were aware of what to do if a patient wanted to complain.

We saw that complaints had been received verbally and by letter. The method of complaints received by the practice had indicated patients knew how to complain. However, most patients we spoke with on the day were not aware of the complaints process but told us that they would speak with a staff member if they needed to complain. Most patients told us that they did not need to complain. One patient we spoke with told us that they complained verbally and that was resolved at the same time.

There was a complaints lead within the practice who dealt with all complaints. We saw that the practice had received three complaints since January 2015. We saw that one

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaint had been resolved on the same day and another had been resolved within a short period. The other complaint was under investigation and had not been resolved at the time of our inspection.

We saw that there was a delay in acknowledgement for one of the complaints. The practice policy which needed reviewing stated that they would be responded within 10 days of the complaint. However, we saw one complaint was responded to after 17 days. The complaints lead told us that when they were away on leave complaints would be left for them to action on their return. This did not ensure that complaints were being handled in line with recognised guidance. They told us that they would be looking to establish a deputy so that they were able to respond to complaints when they were away.

Are services well-led?

Good

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

Our findings

Vision and strategy

This practice was one of three practices within the locality, all of which were owned by the same provider. The mission statement of the practice stated 10 aims and objectives of the practice. Some of those were to ensure the practice provided high quality care in an environment which was safe and welcoming. They were also to involve patients and their carers in decisions about their care; respond to demands of the practice population and to ensure that staff members had suitable training. We saw evidence that the practice was making progress to ensure these aims were being implemented. For example, we saw that efforts were being made to involve patients in the delivery of the service and staff had a training programme in place and were encouraged to complete their training. Staff told us the future changes to the practice were discussed with them and they were encouraged to make suggestions that led to improved systems and patient care.

We spoke with the lead GP who told us that one of GP partner's was being trained as a managing partner for when they retired. We spoke with that GP who confirmed this. This showed that the practice was taking account of the need for succession planning.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at a selection of these policies and procedures; most had been reviewed annually and were up to date.

There was a leadership structure with named members of staff in lead roles. For example, there were two lead nurses for infection control and the senior partner was the lead for safeguarding. There were GP leads for minor surgery, sexual and reproductive care, child health and palliative care. There was a nurse and GP lead for diabetes care as well as nurse leads for immunisations. Staff we spoke with 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.

During our previous inspection we found that there was no clear governance structure at the practice. At this inspection one of the GPs we spoke with told us that they were the governance lead at the practice. They had started recently and told us that work was ongoing in this area. They told us that weekly meetings were established along significant events and complaints analysis. Lunchtime meeting for continuous professional development (CPD) activities were introduced as well as performance reviews for referrals amongst others. They showed us a document with components of clinical governance they were using to develop the governance arrangements in the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. 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 e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. Staff members we spoke with, including the practice manager, and minutes of meetings we looked at confirmed this. For example, clinical meetings held in December 2014 showed that the practice had appointed a lead for QOF and co-ordinate this across the three registered practices. We saw that updates were shared and discussed in subsequent meetings. The latest QOF data for this practice showed it was performing above local and national standards.

The practice manger was responsible for the day to day running of the three practices. To support the practice manger in running the practices effectively, there were site managers. Only one of the site managers was available on the day of the inspection and they told us that they were also the lead for complaints. There were meetings in place to ensure that policies and strategies were implemented consistently across the three practices. However, the practice manager was not fully supported to carry out their role. The practice manager told us that they also worked as an advanced nurse practitioner and that they spent 70% of their time in this role. This did not ensure that they had adequate time to fulfil their role effectively as a practice manager for the three locations. From our discussion with the practice manager we found that they did not have an overall understanding of the operational needs and knowledge of the three practices. For example, when asked, the practice manager was unable to tell us if the practice had a business continuity plan in place or if a

Are services well-led?

Good

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

legionella risk assessment had been carried out. We had identified this as an issue in our previous inspection in August 2014. The practice manager told us that since the inspection in August 2014 site managers for each of the three locations had been introduced and they normally delegated tasks to the site managers.

Leadership, openness and transparency

Although the practice manager did not have adequate time to fulfil their role effectively there was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through individual appraisals. Staff members we spoke with confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

We saw minutes of clinical meetings that were held weekly and attended by the practice manager. Staff and the practice manager told us that information from those meetings was shared with staff. We saw that practice meetings were held monthly and the GPs and staff spoken with confirmed this.

Practice seeks and acts on feedback from its patients, the public and staff

The three practices had an active patient participation group (PPG). The group consisted of clinical and non-clinical staff from the practices and approximately six patients. We spoke with the chair of the group and two other members during our inspection 25 March 2015. They told us that the PPG had been in place since October 2014 and meetings were held every three months. We saw minutes which confirmed that meetings were taking place. The chair of the PPG group told us that in the first meeting the practice had discussed areas for improvement. We saw this had included access to appointments, and the group were asked for feedback on this.

We were told by a staff member that each practice completed a six monthly mini patient questionnaire, we were shown an example of this which had been completed in July 2014. They told us that a full survey was completed annually. We were given a copy of the results from the last survey which was also available on the practice website. We saw that an action plan had been developed from the findings of the survey. For example, access was recognised as an issue by patients and the practice had increased the number of phone lines and number of telephone consultations available.

Staff we spoke with told us that the practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. However the policy did not include actions or contacts for staff should they need to raise a concern outside of the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals and monthly 1to1 meetings took place which included a personal development plan. Staff told us that the practice was very supportive of training. For example, a GP was supported to attend various courses including palliative care and sexual health. This GP was the lead for sexual health and palliative care.

We saw regular weekly clinical meetings were held to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt. The practice had completed reviews of significant events and other incidents and shared with staff at meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.** **The provider must ensure care and treatment is provided by ensuring proper and safe management of medicines through current and up to date medicine directives. Regulation 12 (2)(g)**