Dr Zuber Ahmed

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr Z Ahmed at Sun Valley medical Practice Oldham.

We carried out a comprehensive inspection on 3rd March 2015. We spoke with patients, a member of the patient participation group (PPG), and staff including the management team.

The practice is rated as Good. A safe, effective, caring, responsive and well-led service is provided that meets the needs of the population it serves.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support improvement.
- The practice was using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice. It was involved in a local scheme with community groups where a holistic approach to health and social care is being trialled.
- Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.
- The practice implements suggestions for improvements and makes changes to the way it delivers services as a consequence of feedback directly from patients, community groups and from the Patient Participation Group (PPG).
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

- The practice had secured external funding and was actively working with a housing association group to screen and manage patients registered with GPs across the locality for the early signs of dementia.
- The practice had close links with local community groups for ethnic minority population groups in the locality and was active in assisting these groups to manage the expectations of their members in a number of health related issues including choosing a 'preferred place to die'.
- The practice had volunteered to facilitate MIND with space within the practice for two days per week to assist patients with Improving Access to Psychological Therapies (IAPT). MIND is a mental health charity that works to reduce the stigma and raise awareness of mental health problems.
- Patients over 75 years of age residing at home or in a care home, patients with a diagnosis of dementia or those on the palliative care register had access to a named 'champion' within the administration team to assist them with any access, complaints or questions they may have. This 'champion' rang the patients weekly to ask if they had any needs they could assist with.

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

The provider should:

- Ensure multi-disciplinary meetings are fully recorded and shared with all members of the meeting.
- Ensure an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Raise awareness of risk management within the practice with all staff groups and document risk assessments.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risk management was comprehensive however was not embedded with all staff groups.

Safeguarding training was on-going for all staff and all staff we spoke with were aware of the safeguarding adults and children policies within the practice. The GP was the lead for safeguarding and liaised with external agencies as required.

The practice was clean and tidy

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. The practice had links to neighbouring practices to share best practice.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health.

Staff had access and protected time for training appropriate to their roles, a new eLearning system had recently been purchased to ensure training was completed in a timely manner.

Appraisals and personal development plans were in place for all staff. Multidisciplinary working was evidenced.

The practice was using innovative and proactive methods to improve patient outcomes including working with local community groups.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect. Patients said they were involved in decisions about their care and treatment and that staff, both nurses and GPs, spent time to listen and explain all aspects of care to them.

Summary of findings

We received 19 comments cards and spoke to seven patients on the day; on the whole comments were positive however we did hear that getting through to the practice by phone at 8.30 am is a problem.

We observed a patient centred culture and staff were motivated and inspired to offer kind and compassionate care. Staff were familiar with patients and recognised when patients needed extra support or assistance and strived to ensure this need was met. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Accessible information was provided to help patients understand the care available to them.

Are services responsive to people's needs?

Outstanding

The practice was rated as outstanding for providing responsive services. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice had implemented innovative processes to ensure they could respond to the needs of all their population groups. They had reviewed the needs of their local population and engaged with other services in the area, including community and housing services.

The practice used administration staff as champions to assist elderly patients, those with dementia or on the palliative care register to access healthcare as appropriate to their ongoing condition. These champions rang the patients on a weekly basis or were available as a named contact if the patient rang the practice for assistance with their needs.

Most patients reported excellent access to the practice, with telephone and face to face appointments almost always available on the day requested. All children under 5 and vulnerable adults including patients with mental health and dementia needs were seen on the day regardless of availability of appointments.

There was an accessible complaints system and we saw the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice was rated as good providing for well-led services.

Summary of findings

The lead GP had a clear vision which was shared by all the staff, the vision had patients as its top priority. Staff worked well with the other practices within the locality to share expertise. We found there was a high level of constructive staff engagement and a high level of staff satisfaction.

There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued and rewarded for the jobs they undertook and they were encouraged and trained to improve their skill sets.

The practice sought feedback from patients, and had an active patient participation group (PPG).

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 kept a register of those patients 75 and over and was on target to have completed 50% of the required care plans. The practice offered a named GP for these patients in line with the new GP regulations. They were responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was in line with the national average at 75%.

The practice had a telephone appointment line available each day specifically for patients over 75 years to contact the practice if they felt too ill to visit the surgery. There were also 'champions' in place for these patients and for those who had dementia or were on the palliative care register. These champions rang the patients on a weekly basis or were the direct contact for those patients who rang the practice needing support with their on-going needs.

The practice supported all the health needs of patients residing in four local care homes and had patients residing in two further care homes a total of 69 patients.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them but were awaiting planned update training relevant to their role.

People with long term conditions

Good

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

The practice had identified key staff for the management of patients with long term conditions. A register was maintained of patients with more complex care needs. There were identified appointments every day for patients with long term conditions and when these were taken reception staff sent an electronic message to the GP and asked where they should slot the patients into their clinics. Patients were seen at a time when their need was greatest. The out of hour's

services and other community health staff were alerted to any possible emergencies that could occur. Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due.

Families, children and young people

Good

The practice was rated a good for the care of families, children and young people.

Staff knew their patient population well and we saw a system in place to identify children or parents at risk. Children and young people were treated in an age appropriate way and their consent to treatment using appropriate methods was requested. Baby immunisation clinics and mother and baby clinics with a nurse and GP were available. Any child due an immunisation or baby check was sent an invitation by the Child Health Department.

Children under five years were seen on the day of their appointment request. Clinical staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and they were trained to a level relevant to their role. Children with high A&E attendance or on the 'at risk' register were discussed with the multi-disciplinary team at the Monday practice meetings.

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).

Extended opening times for evening and Saturday morning appointments were available. These were for those who particularly struggled to see a GP due to work commitments. Flexible appointment systems were available via telephone or on line. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Late evening appointments were available for people who found it difficult to attend during the day.

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 was aware of, and identified their vulnerable patients. This was highlighted by a flagging system within the patient

electronic records. The practice discussed any concerns regarding these patients at weekly multi-disciplinary team meetings. Safeguarding policies and protocols were in place. The safeguarding lead was a GP who had received appropriate training. Not all GPs were trained to level 3 however the lead GP had planned further training to address this. Training for all other staff was ongoing and at a level to suit their role.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability and offered longer appointments and offered home visits if required.

The practice had 1% of its population who were either asylum seekers or were known to the home office for outstaying their right to reside in the UK. These patients were asked to provide proof of their home office applications to ensure they received care appropriate to their circumstances.

Health promotion leaflets were available in languages which reflected the patient population and there was access to translation services on site, through language line and pre booked translator services for people whose first language was not English.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

All staff at the practice had completed dementia training which gave them an understanding of dementia and the things that could make a difference to people living in their community.

The lead GP had successfully attracted funding from a national media source to help identify patients with cognitive decline., In association with a local housing association an electronic multi-lingual dementia assessment tool was in use. This was used in the community areas of the town to assess the needs of population groups who do not readily come forward for this type of testing.

The practice had volunteered to accommodate MIND to carry out clinics on two days per week to assist patients in the community with Improving Access to Psychological Therapy (IAPT). MIND is a mental health charity that works to reduce the stigma and raise awareness of mental health problems. The provision of this service within the practice environment ensured that patients would not be stigmatised as it appeared that they were attending routine GP appointments.

Summary of findings

Arrangements were made to see more complex patients at the end of the clinic by the lead GP. If a patient had history of aggressive or violent behaviour then the clinical staff would see them with another colleague present.

Summary of findings

What people who use the service say

During our inspection, we spoke with seven patients. They told us that the GPs and the care they received was good. Two patients told us access to appointments especially early in the morning was a problem. A member of the practice's patient participation group (PPG) told us that the practice listened to them and acted on their suggestions.

We received 18 completed CQC comment cards; they all complemented the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated 71% of respondents described their overall experience of this surgery as good and 66% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. 81% of respondents said the GP was good at listening to them with 92% saying they had confidence in the GP. 84% said the reception team were helpful with 91% having trust in the nurse.

Two patients identified issues in trying to get through to the practice on the telephone. However the practice was aware of this concern and was actively seeking solutions to improve patient telephone access.

Areas for improvement

Action the service SHOULD take to improve

- Ensure multi-disciplinary meetings are fully recorded and shared with all members of the meeting.
- Ensure an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Raise awareness of risk management within the practice with all staff groups and document risk assessments.

Outstanding practice

- The practice had secured external funding and was actively working with a local housing association group to screen and manage patients registered with GPs across the locality for the early signs of dementia.
- The practice had close links with local community groups for ethnic minority population groups in the locality and was active in assisting these groups to manage the expectations of their members in a number of health related issues including choosing a 'preferred place to die'.
- The practice had volunteered to facilitate MIND with space within the practice for two days per week to assist patients with Improving Access to Psychological Therapy (IAPT). MIND is a mental health charity that works to reduce the stigma and raise awareness of mental health problems.
- Patients over 75 years of age residing at home or in a care home, patients with a diagnosis of dementia or those on the palliative care register had access to a named 'champion' within the administration team to assist them with any access, complaints or questions they may have. This 'champion' rang the patients weekly to ask if they had any needs they could assist with.

Dr Zuber Ahmed

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP, and a specialist advisor who was a Practice Manager.

Background to Dr Zuber Ahmed

Dr Z Ahmed, Sun Valley Surgery is located in Oldham, within the Oldham Clinical Commissioning Group (CCG.) The practice was located within a CCG managed building alongside a number of other GP practices and community services. The CCG had responsibility for all maintenance contracts including legionella testing for all the practices and community services within the building.

Services are provided under a personal medical service (PMS) contract with NHS England. There are 3469 registered patients. The practice population includes a higher number (29.3%) of people under the age of 18, and a lower number (11.5%) of people over the age of 65, in comparison with the CCG average of 17.2% and 15.1% respectively.

There are comparatively high levels of deprivation in the practice area. Information published by Public Health England, rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice opens from 8.00 am to 6.30 pm Monday to Friday and 10am to 12.30 on Saturdays. Weekday appointments after 6.30pm were available when necessary. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider (Go To Doc).

The practice was single handed with two salaried GPs (one female and one male), one regular locum GP (female for one session per week), one practice nurse, a practice manager (who had only been in post for one month), reception and administration staff.

The nurse has daily clinics both morning and afternoon for patients to book into to.

On line services include; booking appointments and repeat prescription requests.

The premises are purpose built. They house a number of other services including other GP practices, a dentist and a pharmacy and offer access and facilities for disabled patients and visitors.

The CQC intelligent monitoring placed the practice in band 1.The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

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

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

How we carried out this inspection

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

Is it safe?

Is it effective?

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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 3 March 2015.

We spoke with a range of staff including GPs, a practice nurse, a community matron, reception staff, administration staff, the practice manager and two representatives from local community groups on the day. We sought views from patients and representatives of the patient participation group and looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

There were clear lines of leadership and accountability in respect of how significant incidents were investigated and managed.

The practice used a range of information to identify risks and improve patient safety. These included complaints, findings from clinical audits, significant events and feedback from patients and other health and social care professionals. Staff were clear about their responsibilities in reporting any safety incidents.

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

The quality and outcomes framework (QOF), which is a national performance standard, showed that in 2012-2013 the provider was appropriately identifying and reporting incidents. The lead GP told us they completed incident reports and carried out significant event analysis as part of their on-going professional development.

Minutes of meetings evidenced that significant events and changes to practice were discussed at practice meetings and shared with practice staff including the nurse and administration staff if that was deemed appropriate. Action was taken to reduce the risk of recurrence in the future.

Administration and reception staff were aware of what constituted a significant event and knew how to escalate any incidents to the manager but not all staff were aware of the policy.

There were mechanisms in place for the prompt management of safety alerts. These were received directly by the GPs, nurse and practice manager and dealt with as appropriate and a record was kept of any actions taken.

We saw that any complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks. All actions from complaints were shared with staff and the patient participation group as appropriate.

Appropriate arrangements were in place with a building management team supported by the Clinical Commissioning Group for the maintenance of the building. Fire alarms and extinguishers were placed throughout the building. Fire alarms were tested regularly, fire training up dates were planned and fire marshals were identified amongst the staff to assist in the event of a need to evacuate the premises.

The practice manager had been in post for one month but was aware of their responsibilities to notify the Care Quality Commission (CQC) about certain events, such as occurrences that would seriously affect the practice's ability to provide care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. It was clear the practice had an open culture and that staff were encouraged and supported to report any incidents.

Significant events we reviewed (seven in total) showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently and what changes had been carried out. We saw evidence that changes in practice had been implemented. For example protocols had been changed to ensure the situation did not arise again. The lead GP told us they reflected fully on these events at staff meetings however we did not see a documented reflection of the event in the staff meeting minutes. The practice manager assured us this would be added to the agenda for subsequent meetings.

The practice shared an example where a patient with a cancer diagnosis had struggled to get an appointment with the GP. To address this issue the practice now had appointments designated for patients with complex or long term conditions only to access. If these appointments were full the reception staff send an electronic message to the GP and he would then tell them when he could see the patient.

Monthly staff meetings were used to discuss and communicate learning and improvement from complaints and incidents. Minutes from these meetings were shared with all staff. We found staff meetings had only recently started to be formally recorded but diary entries and attendance lists on the diary dates indicted the meetings had gone ahead.

Good

Are services safe?

Multidisciplinary team meetings were carried out on a weekly basis and included attendance from local authority, community matrons, health visitors, children's nurses and any other agencies deemed required. These meeting were again only recorded in the diary with actions carried forward to the next meeting from these entries. The practice need to ensure these meetings are fully recorded and shared with all attendees as soon as possible after the meeting. The practice manager discussed their rational for not having formal records due to patient names and confidential information being recorded but assured us they would anonymise this information and ensure from the next meeting minutes were available.

We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GPs, nurse and practice manager and action was taken as required

Reliable safety systems and processes including safeguarding

All the staff at the practice, including the receptionists, were proactive when following up information received about their patients, specifically those who were vulnerable. Staff had an awareness of how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns contact numbers were readily available and staff told us they would discuss any issue with the practice manager and she would contact the relevant agency. Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew where to locate them.

All staff had completed previously adult safeguarding and child safeguarding to a level appropriate to their role, with the lead GP being trained to level 3. Update training was scheduled within the practice timetable as a new E Learning package was now available for staff to complete. Staff had access to protected learning time to assist them to complete this training. This new system was supported by Blue Stream on-line training. Blue Stream Academy are providers of eLearning/online training for GP practices.

The safeguarding records and register at the practice were updated on a weekly basis following discussion and meeting with the GP and other professionals involved in the care. The practice was able to inform us of the number of children and vulnerable adults currently on their register and where they were in the process. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities (LD).

The practice had a high population from black and minority ethnic (BME) groups and had had to amend their model of care to accommodate this group of patients as they were not familiar with being treated within a primary care model for their care. The GPs discussed with us the challenges this had presented for them, amongst which was the patients expectation to be seen in the local NHS Trust for all their needs once discussed with the GP. 1% of the practice population were either asylum seekers or patients who had overstayed their travel visas in the country. The practice systems and processes had had to be addressed to allow this group of patients to be treated fully for their needs. Problems had included communication and language issues alongside gaining the confidence of the patients for them to allow the practice to assist them with their ill health. Translation services were readily available at the practice.

Patients we spoke with told us they were aware of the availability of chaperones. Some reception staff undertook chaperoning when a clinical person was not available and had training for this role. Details about chaperone facilities were available in the practice.

Each consultation and treatment room had a panic alarm on the computer system and a button on the wall to seek assistance in an emergency from other staff members. Staff told us the panic button on the wall was regularly activated by children pushing the button but they always responded in a timely manner.

Medicines management

Systems were in place for the management of medicines.

Medicine management was an agenda item on all clinical meetings with the lead GP taking responsibility for this alongside the CCG medicines management pharmacist who supported the practice. Medicine optimisation which is the review of multiple medicines taken by an individual patient to ensure they are the right medicine for them and they remain appropriate for their needs, was high on the practice agenda.

Good

Are services safe?

We saw from data produced at CCG level that audits were carried out by the CCG medicines management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

Emergency medicines for cardiac arrest were available within the building they were stored securely in the reception area. We checked the emergency drug boxes and saw that medicines were in date. We found the building had a defibrillator available to all practices and access to oxygen for use in emergency. The practice also held their own supply of medicines to be used in the event of emergency including medicines to be used for anaphylaxis (an adverse reaction to a medicine) and hypoglycaemia (low blood sugar) and we found these were stored securely in each consulting room and were all in date.

We saw other medicines stored within the practice were in date and systems were in place to check expiry dates. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

The nurse had a stocked anaphylaxis medicine box which she took out with her when she visited patients in their home for flu vaccinations. This was checked and was all in date.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. The electricity mains plugs for the fridges were coloured red and labelled not to be removed which reduced the risk of them being inadvertently disconnected. There was a clear cold chain protocol in place that followed NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.

Medicine reviews were conducted by the GP's and any changes were fully recorded in the patient's electronic records.

The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. The practice processed repeat prescriptions within 24-48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs.

The practice checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes.

Security measures were in place for prescriptions within the practice, access was in line with suggested best practice within the NHS Protect Security of prescription forms guidance, August 2013. We were told hand written prescriptions were rarely used other than on home visits however these were not tracked fully. The practice assured us after our discussion they would ensure all prescription numbers from these pads were recorded and audited on a monthly basis.

We saw recent medicine alerts had been discussed at the practice clinical meetings.

The practice had action plans in place to address areas highlighted in the CCG medicine management data as being outside the medication prescribing limits. We saw that improvements had been made with any outlying issues identified in information we had been provided with. These were closely monitored by the CCG.

Cleanliness and infection control

Infection Prevention and Control (IPC) was monitored within the practice and the IPC policy was available to all staff. This gave full information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. There was an identified IPC lead who was working with support from the local NHS IPC lead to ensure all aspects of the policy were implemented fully. The lead had attended training to carry out their role however as she was relatively new in post this had not been her priority we were assured going forward she would ensure this was fully addressed.

IPC training on hand washing had been provided to all staff, and we saw evidence IPC training was available on the practice ELearning system to be completed on an annual basis. Staff were aware of the infection control lead.

We observed the premises to be clean and tidy and saw facilities such as hand gels; paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in all the patient toilets. We saw there was hand

washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Protective equipment such as gloves, aprons and masks were readily available.

Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin secured to the wall. There was a record of when each bin started to be used.

Cleaners were employed by the building management team. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis this was not held by the practice. The practice was cleaned in line with infection control guidelines, with the cleaners routinely attending every day. The IPC lead told us chairs had recently been steam cleaned and curtains around examination couches changed by the cleaning staff.

An IPC audit had not been carried out in the last 12 months but the IPC lead was in the process of addressing this.

Equipment

There were contracts in place for annual checks of portable appliance testing and calibration of equipment such as spirometers, used to help breathing, which were maintained to International Organisation Standardisation (ISO) guidelines. We saw evidence that portable appliance testing had been undertaken and was up to date and calibration of equipment had been carried out where necessary.

Emergency drugs were stored in line with good practice guidelines and vaccines were appropriately stored in fridges specific for that purpose. The fridge temperatures were checked daily and we saw logs to ensure that these were within acceptable limits. A log of maintenance was in place and a record noted when faults were identified.

Staffing and recruitment

The practice recruitment policy had recently been updated. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service.

All the GPs had disclosure and barring service (DBS) checks undertaken annually by NHS England as part of their appraisal and revalidation process. The nurse also had a recent DBS check.

The practice currently had an apprentice working with them who was supported by the local college, this allowed them to encourage young people living in the local area with local knowledge to join the practice and bring with them cultural skills to assist patients registered with the practice.

The staff were multi skilled which enabled them to cover each other in the event of planned and unplanned absence.

The practice GPs covered each other's absence as much as possible with the use of a regular locum to cover any sessions as required.

The practice routinely checked the professional registration status of GPs and practice nurse against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications and equipment. Environment risk assessments however were not formally recorded. The practice should ensure all staff are aware of risks in the workplace and the effective management of these risks should be recorded fully.

All incidents were discussed at staff meetings and staff told us that learning was always seen as a positive aspect of these incidents to make sure the incident could be avoided next time.

The practice had a system in place for reporting, recording and monitoring significant events.

The practice management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness.

The practice had an identified fire marshal on duty every day.

Fire extinguishers and alarms were checked and maintained by the building maintenance company supported by the CCG.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had a current business continuity plan in place. This plan gave staff detailed up dated guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Reception staff told us they were aware of the plan but did not know where the document was located; they told us they would go to the practice manager.

Records showed that staff needed to update their fire training. The new manager was aware of this and assured us this would be actioned in the near future.

Emergency equipment was available and included a defibrillator and oxygen. Checks were undertaken to ensure they were ready for use and in date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

New patient health checks were carried out by the practice nurses and cardiovascular and other regular health checks and screenings were on-going in line with national expectations.

People with long term conditions (LTC) were helped and encouraged to self-manage, and checks for blood counts, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach. The practice held a number of on the day appointments specifically for patients with LTC to ensure they could access support as and when they needed it.

Care plans had been put in place for 2% of the practice patients who met the criteria to avoid unplanned admissions to hospital. This was part of local enhanced services.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions. The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

Multi-disciplinary meetings were held weekly to discuss patients making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

Patients spoken with said they received care appropriate to their needs. They told us they were included as much as possible and were helped to come to decisions about the treatment they required.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We were shown evidence of seven completed audit cycles.

Examples of clinical audits included an audit to review the appropriate prescribing of Clopidigrel which is a medicine used for some patients following heart attacks or strokes. The audit aimed to check that the medicine had been stopped after the recommended time. The audit addressed all patients currently taking the medication and alerted GPs to the end date for their treatment with this medicine. The practice found they were working in line with recommendations and this would be re audited in the future to check this compliance was maintained.

Another audit involved checking if patients who had problems with overactive thyroid were receiving their annual blood tests in line with guidelines from the National Institute for Health and Care Excellence (NICE). The practice aim was to have 70% of these patients having annual checks but they found they only achieved 49.3% at the end of the first cycle. This audit was repeated after implementing changes such as flagging patients on the electronic system as requiring the test. At the second audit six months later the practice found they achieved 70.3% of patients requiring the test actually having recorded test results. Further discussion highlighted extra changes that may assist this audit to reach 100% these have all been implemented and the audit will be repeated in the future.

The practice reviewed patients under a locally enhanced service to minimise unplanned admissions to hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments.

One salaried GP undertook minor surgical procedures within the practice in line with their registration and NICE guidance.

Regular meetings took place with multi-disciplinary attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with the local community matrons, school nurses, health visitors, district nurses and palliative care staff which resulted in positive outcomes for the patients concerned.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

All the staff at the practice were complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. The practice had recently introduced a new training system for ELearning. This new system was supported by Blue Stream on-line training. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. Most staff were multi-skilled and able to carry out the role of their colleagues as required to cover absence.

There was an induction process for new staff which covered the practice ethos, introduction to policies and procedures and duty of care.

Doctors were revalidated, nurse professional registrations were up to date and appraisals were carried out annually on all staff although we did observe that the practice nurse had not yet been appraised.

All patients we spoke with were complimentary about the staff and we observed staff who were competent, comfortable and knowledgeable about the role they undertook.

There was enough staff to meet the demands of the practice.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services to maintain safe and effective care for their vulnerable patients. Regular communication and meetings with the local social services assisted this process.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hour's service in relation to patients receiving palliative care and if patients had signed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

The practice had a close working relationship with Oldham Clinical Commissioning Group (CCG) and worked collaboratively on a number of both national and local initiatives.

The practice worked closely with local community groups to ensure healthcare information reached groups of patients from black and minority ethnic communities.

The practice had successfully attracted funding from a national source to work in collaboration with a local housing association company to help identify patients with cognitive decline, bringing initial testing for dementia to hard to reach groups in the locality. They were using Cantab Mobile, this was developed by Cambridge University as a way of assessing episodic memory without language barriers. The process is sensitive to Alzheimer's disease and mild cognitive impairment. This had been administered in the local mosque; local community centres and was now being administered in the practice on Saturday mornings with open access for all people from the local community. People gave electronic consent then completed a multi-lingual test on a supplied electronic device and their results were then collated and sent to the lead GP. He then wrote to the patient and informed their own GP of their results and any action needed was addressed by the patient's own GP. The GP also worked closely with the local mosque and regularly gave information sessions to specific groups of the community on pertinent topics such as diabetes, dementia and women's health issues.

The lead GP worked closely with the Pakistani community centre and their leaders to ensure health and wellbeing information was shared appropriately with this group of people. Information giving sessions were arranged for users of the centre to try to keep them informed of changes and advances in health care provision in the area. The luncheon club attendees had recently been encouraged to complete the Cantab mobile dementia testing programme, this had been well received and the GP intended to audit the outcomes and onward referrals from this testing.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice. CQC comments cards also confirmed patients felt they had been referred for hospital appointments within an appropriate timescale.

The practice had volunteered space for MIND to allow them to see patients within the practice for their interactive psychological therapy sessions. This assisted both the practice and the patient, the practice could directly refer to the service. Patients benefited as they could attend their

Good

Are services effective?

(for example, treatment is effective)

own GP practice, access the sessions and not be tagged with the stigma of attending a mental health consultation as it appeared they were just attending their GP practice. MIND is a mental health charity that works to reduce the stigma and raise awareness of mental health problems.

The practice worked very closely with the community matrons, one matron told us they could always get in to speak to the GPs about any concerns they may have at short notice. They told us the GPs were approachable and receptive to their comments and any changes they suggested in the care of patients registered with the practice.

Information Sharing

Information about significant events was shared at practice meetings. The lead GP attended CCG meetings and shared what they had learned in practice meetings. This kept all staff up to date with current information around local enhanced services, requirements in the community and local families or children at risk.

The practice used electronic systems to communicate with other providers. The out of hour's services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated.

There was a practice website with information for patients including signposting, services available and latest news. There was also a monthly patient newsletter from the patient participation group and information leaflets available within the practice waiting room and at the request of any of the clinicians if a patient required more private information.

Patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend multi-disciplinary team meetings.

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure

information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GPs and the nurse we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff told us they had received training in regards to consent but had not received formal training for the Mental Capacity Act 2005 (MCA); however they assured us they had read the available documentation to ensure they were fully orientated with the requirements of the act. GPs and clinicians were aware of the MCA and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. Written consent was used for minor operations and was scanned into the patient's electronic records.

The practice policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This ensured where possible that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate.

The latest National GP patient survey published in January 2015 indicated 80% of people at the practice said the last GP they saw or spoke to was good or very good at explaining tests and treatments, 75% said the last GP they saw or spoke to was good or very good at treating them with care and concern and 91% had confidence and trust in the last nurse they saw or spoke to.

Staff informed us they had access to interpreter translation services on site and by appointment or electronically for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use.

Health Promotion & Prevention

All new patients were offered a consultation and health check with the practice nurse. This included discussions

Good

Are services effective?

(for example, treatment is effective)

about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The waiting rooms were well organised and had straight forward directions and advice on them.

The practice offered NHS Health Checks to all patients aged 40 to 74 years old.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. Patients on disease registers were offered reviews with the nurse. The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in January 2015 demonstrated 66% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. 91% said they trusted the nurse with 92% saying they had trust in the GP. 81% said the GP was good at listening to them.

We received 18 completed CQC comment cards; most praised the practice. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Verbal feedback from two patients we spoke with on the day identified issues in trying to get through to the practice on the telephone early in the morning. This issue was an area identified for improvement in the National Patient Survey with 38% of respondents stating they found it difficult to get through to the surgery by phone early in the morning. This was below the CCG average. However the practice was aware of this concern and minutes of meetings demonstrated that they were actively seeking solutions to improve patient telephone access.

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity such as longer appointments at the end of the day or appointments within a specific time period due to mental health needs or learning disabilities.

All consultations and treatments were carried out in the privacy of a consulting room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff and patients informed us they were aware there was an interview room available if patients or family members requested a private discussion.

We were told by a member of the patient participation group (PPG) that the practice listened to their comments at the meetings and they felt they could influence changes in the practice in the future. They told us the practice used to make changes without conferring with them but this has now changed and all changes are fully consulted upon before being implemented. The PPG members were complimentary about the service provided by the practice due to the diverse population groups included in the patient list.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. They told us they felt listened to and time was taken to assist them to understand what was happening to them, they also said they were offered options to help them deal with their diagnosis.

The National GP Patient Survey published in January 2015 identified 76% of respondents felt that the last GP they saw or spoke to was good at giving them enough time; 92% of respondents had confidence and trust in the last GP they saw or spoke to and 80% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments.

Staff told us that translation services were available on site for patients who did not have English as a first language. Patient information leaflets were available in other languages.

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room, and on the practice website told patients how to access a number of support groups and organisations. The practice staff confirmed that they were actively identifying patients who were also carers.

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs.

Multi-disciplinary supportive care meetings were held to discuss the needs of those approaching end of life. Patient preferences were shared electronically with appropriate healthcare partners to ensure they were met, for example, with the out of hour's services.

The practice had systems in place that reflected best practice for patients nearing the end of their life and

Good

Are services caring?

demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told that in appropriate cases GPs had conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation with patients. This was to ensure patient's wishes were managed in a sensitive and appropriate way.

The lead GP had recently held a session a local Pakistani Community Centre with their members to discuss their 'preferred place to die' with them. Historically patients from this group have accessed the local NHS to end their life and the GP wanted to make members of this community aware of their options at this time in their life. The session according to the community leader we spoke with had been well received and members felt they had gained information to help them plan with their families for their end of life care.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due.

The NHS Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and had identified service improvement plans. This had included improving access to the service for patients for appointments. Late extended opening times had been implemented specifically for those patients who worked alongside a Saturday morning clinic.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurses to receive their influenza vaccinations.

Practice staff pro-actively followed up information received about vulnerable patients.

Longer appointments could be made for patients such as those with long term conditions, learning disabilities, mental health needs or who were carers.

GPs confirmed that all patients over 75 years had a named GP and the practice was on target to have in place completed care plans for this patient group. A coding system on the computer system in the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities. The practice had dedicated champions who rang patients who were over 75 years old living in their own home or care environments, had a diagnosis of dementia or were on the palliative care register. This champion was also available for the patent if they needed to ring the practice to access support with heath care needs.

The practice had also implemented suggestions for improvements where possible in response to feedback from the patient participation group (PPG). One member of the PPG told us the practice was proactively trying to gain feedback from patients and trying to encourage more patients to join the group in order to determine how to improve and meet the needs of the population it served.

The practice also responded to the needs of the practice staff, we saw a notice on a consulting room door indicating one GP was not to be disturbed as he was currently at prayer. Staff told us their personal and professional needs were supported where possible always responded to in a positive manner.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was a large waiting area for patients attending an appointment and some car parking was available nearby. Baby changing and disabled toilet facilities were available.

A number of the practice health promotion leaflets had been translated into other languages. This enabled them to direct appropriate support and information to the different groups of patients

The practice currently had over 50% of their registered patients from diverse population groups. The practice had taken appropriate measures to ensure these patients received appropriate timely care and that they fully understood their treatment. They had tailored services and support around the practice populations needs and provided a good service to all patient population groups. The practice staff spoke a variety of languages and were from a variety of population groups so could assist patients within the practice. Staff had access to a translator on site every day and could also access appointments for translators and language line. The practice health promotion leaflets had been translated into other languages. This enabled them to direct appropriate support and information to the different groups of patients

The practice had systems in place to ensure people experiencing poor mental health had received an annual

physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service. The practice referred patients for counselling where appropriate with MIND who ran clinics on site.

The lead GP worked closely with the Pakistani community centre and their leaders to ensure health and wellbeing information was shared appropriately with this group of people. Information giving sessions were arranged for users of the centre to try to keep them informed of changes and advances in health care provision in the area. The luncheon club attendees had recently been encouraged to complete the Cantab mobile dementia testing programme, this had been well received and the GP intended to audit the outcomes and onward referrals from this testing.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site. The practice operated a choice of same day appointments and those which could be booked in advance.

68% of respondents to the latest GP patient survey said that they were satisfied with the practice opening times.

From the completed CQC comment cards and speaking with patients we were told appointments were usually on time with not too much waiting. One patient told us they experienced problems contacting the practice as soon as it opened but if they waited 30 minutes they could get through no problem however all the emergency appointments may have gone by this time. They did also say they were confident if they needed seeing on the day the practice would arrange an appointment at some point.

Late evening appointments via an extended surgery were available each day from 5.30pm to 7.30pm. These appointments were aimed at patients who struggled to see a doctor due to work commitments. Appointments were also available on Saturday morning from 9am until 11am.

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or for patients with learning difficulties and mental health issues to ensure time was appropriately spent with patients.

The practice had volunteered space for MIND to allow them to see patients within the practice for their interactive psychological therapy sessions. This assisted both the practice and the patient, the practice could directly refer to the service. MIND is a mental health charity that works to reduce the stigma and raise awareness of mental health problems.

Appointments at the end of the GPs surgery were available for patients who felt they needed more time. The GP told us patients are used to these appointments now and actually tell reception staff they need an appointment at the end of the surgery.

Arrangements were made to see more complex patients at the end of the clinic by the lead GP. If a patient had history of aggressive or violent behaviour then the clinical staff would see them with another colleague present

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We reviewed how the practice managed complaints within the last 12 months. Nine complaints had been made by patients or family of patients. We found the practice handled and responded to complaints well. Complainants always received acknowledgement of the complaint and complaints were investigated and documented in a timely manner as required.

Investigations addressed the original issues raised and action was taken to rectify problems.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site.

The PPG member we spoke with told us they discussed complaints and any actions needed at their meetings.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a formal complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice did not have a written strategy however it was evident that all staff within the practice worked to the same ethos. Staff throughout the practice shared the same vision. They were able to tell us what changes were planned for the practice.

All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure however the lead GP took responsibility for most of the daily running of the practice. We saw evidence that showed the GP met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. This was then shared with staff at the practice meetings.

Governance arrangements

There were clear lines of responsibility and accountability for the clinical and non-clinical staff. The practice held weekly clinical multi-disciplinary team meetings (MDT). Practice staff meetings were held monthly.

We looked at minutes from recent practice meetings and found that performance, quality and risks had been discussed. The minutes showed what actions needed to be taken and who was responsible. MDT meeting minutes were not formally recorded at the time of the inspection but we were assured they would be in future.

It was evident that staff were able to raise concerns in a constructive manner. Staff were able to describe how they would raise any concerns and explained how feedback and action was disseminated to staff.

The practice participated in the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed its performance was relatively low at 73.2% against CCG and national standards at 93.4% and 94% respectively. The lead GP was aware of this and was actioning this to try to achieve a higher percentage. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The culture at the practice was open and fair. Staff told us they felt comfortable raising any issues or concerns and that they had the opportunity to discuss with any member of the senior management team.

The practice policies were available in hard copy to staff. Staff we spoke with knew where to find these policies if required. Some policies were in need of update to reflect changes within the practice; this was being addressed by the new practice manager.

Staff said they were supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to any of the GPs if they felt they had any worries.

The practice prided itself on having a 'no blame' culture and staff commented this was the case.

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

The practice actively sought feedback from patients through patient surveys and complaints received. We looked at the results of the 2014 GP patient survey. It reflected mixed levels of satisfaction with the care, treatment and services provided at the practice. However where issues were identified action had been taken to address them.

We spoke with a member of the PPG who confirmed the practice and the PPG were continually seeking patients to join the PPG. The group was slowly increasing in numbers and had ten active members. Despite many invitations representation was required from patients from ethnic groups, such as Asian and Eastern European. The PPG were actively encouraging young members to the group but this had also proved very difficult. The PPG had plans to also operate a virtual group to try to get people to join; this would run in tandem with the current face to face group.

We saw evidence from meeting minutes that the practice did act on feedback and information raised via the PPG.

The practice gathered feedback from all staff grades through discussion and their open door policy. When we looked at staff files it was clear that individual performance was monitored and that personal and professional development was encouraged.

Management lead through learning and improvement

Are services well-led?

Good

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

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The GPs were involved in the local clinical meetings and one GP led on medicine management for the CCG.

Similarly the practice nurse regularly attended their professional forum groups established by the CCG to provide training and support and share good practice.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge.

The GPs discussed the challenges for services whilst experiencing funding changes however the practice aimed to be innovative and participate in future locality developments, working closely with other practices in a federated style and the CCG.

The practice completed reviews of significant events and other incidents and shared with staff to ensure the practice learned from and took action, which improved outcomes for patients.