RJ Mitchell Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at RJ Mitchell Medical Centre practice on 11 February 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw an area of outstanding practice:

- Any patients who deliberately self-harmed were identified from A&E discharges and were invited for mental health assessment and support.

Summary of findings

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

- Ensure the completion of criminal record checks using the Disclosure and Barring service (DBS) prior to the commencement of clinical staff working with patients.
- Ensure prescribers on home visits, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying as per NHS Protect Guidance, August 2013.

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, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Some recruitment checks had not been completed prior to staff members appointment to the practice. The practice had recognised this and were in the process of completion of these checks. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Any patients who deliberately self harmed were identified from A&E discharges and were invited for mental health assessment and support. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The majority of patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

appointments available the same day. The patients with care plans had access to the practice and to their nominated GP by a separate telephone line. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. 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. The PPG had conducted a telephone access survey at the practice in response to the national GP survey feedback and reported their findings to the practice manager./ Service improvements were made and continue to be monitored by the practice and PPG. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Older people with complex needs such as having a long term condition or those on multiple medicines had care plans in place. As part of the Directed Enhanced Services (DES) the patients with care plans had access to the practice and to their nominated GP by a separate telephone line. (DES are schemes that commissioners are required to establish or to offer contractors the opportunity to provide, linked to national priorities and agreements.) The GP informed us the separate line was responded to as soon as practicable. Should these patients be discharged from hospital, then the GP telephoned within 72 hours to ensure that they had necessary medication as well as the social care to support their health and wellbeing.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing 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. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were

Summary of findings

recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. 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. The practice opened for an additional hour each Monday at each location until 7.30pm to improve access for working age people.

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. Patients were offered an annual physical health check. Practice records showed they had received a check up in the last 12 months. The practice used a read code system to ensure they held recorded details of patients' carers or the people involved in supporting them. There were a small number of patients with a learning disability registered at the practice and were therefore well known to staff.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All patients with a mental health care plan had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental

health, including those with dementia. The practice maintained a register of patients with dementia and was involved with multidisciplinary teams such as the Integrated Local Care Team (ILCT), to support patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. (MIND and SANE are mental health support charities which aim to provide advice and support to empower anyone experiencing mental health problems). It 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.

We saw for example that any patients who deliberately self harmed were identified from A&E discharges and were invited for mental health assessment and management. These patients were highlighted on the practice computer system. As part of the practices innovation to improve services for their patients, a mental health counsellor had a weekly surgery to support people with poor mental health.

Summary of findings

What people who use the service say

We spoke with three patients during the inspection and received 65 completed Care Quality Commission (CQC) comments cards in total, 34 of which were from patients registered at the branch practice, Waterhayes Surgery. The majority of the patients we spoke with said they were happy with the service they received overall. Twenty-six of the 65 patients said the service was excellent or very good and 38 patients said that the service was good. The Waterhayes Surgery patients were positive about access to the surgery including making appointments. Comment cards from five patients said they had experienced difficulties getting through to the RJ Mitchell practice location by telephone to make an appointment. Patients' comments were overwhelmingly positive in respect of the care, treatment provided by the GP and nurses and of the attitude and approach of the practice reception staff.

A patient survey was conducted in March 2014 by the Patient Participation Group (PPG).150 questionnaires were given out for patients to complete and 130 were completed focusing on the area of appointment bookings as this had been highlighted as a source of concern. The practice as a result of the survey instigated a number of measures to improve the service. The National GP patient survey 2015 results for this practice found that 91% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was above the local Clinical Commissioning Group (CCG) average of 84%. This was based on findings from the 111 surveys returned out of the 359 surveys sent out, giving a 31% completion rate. There were 67% of respondents who found they usually get to see or speak with their preferred GP which was higher than the CCG average of 55%. It found that 68% of respondents found it easy to get through to the practice by phone, which was lower than the local CCG average of 75%. The percentage of patients that would recommend their practice was 79.6% and 88% described their overall experience of this practice as good.

Patients did not identify any problems specifically with confidentiality at the reception desk. Patients were aware they could ask to speak to the reception staff in another room if they wanted to speak in confidence.

The GPs and practice manager engaged with and acted on feedback from their Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are taken into consideration and to work in partnership with the surgery to improve common understanding.

Patients we spoke with told us they were aware of chaperones being available during examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GP, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Ensure the completion of criminal record checks using the Disclosure and Barring service (DBS) prior to the commencement of clinical staff working with patients.

Ensure prescribers on home visits, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying as per NHS Protect Guidance, August 2013.

Outstanding practice

Any patients who deliberately self-harmed were identified from A&E discharges and were invited for mental health assessment and support.

RJ Mitchell Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to RJ Mitchell Medical Centre

RJ Mitchell Medical Centre is located in Talke, Stoke On Trent and is part of the NHS North Staffordshire Clinical Commissioning Group. The practice has a branch practice, Waterhayes Surgery located at Crackley Bank, Newcastle, Staffordshire. The total practice patient population is 4344. The practice is in an area considered as a fifth more deprived when compared nationally. People living in more deprived areas tend to have greater need for health services.

The staff team currently comprises two male partner GPs each providing full day practice sessions and a female partner. The practice team includes a practice manager, two practice nurses, a senior receptionist and nine reception/administration staff. Excluding the GPs there are 13 staff in total employed either full or part time hours.

RJ Mitchell Medical Centre opening times are Monday 8am to 7.30pm, Tuesday to Friday 8am to 6.30pm with the exception of Thursdays when the surgery times are 8am to 1pm at the Waterhayes Surgery and 8am to 1pm at the RJ Mitchell Medical Centre, Talke.

The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through the Staffordshire Doctors Urgent Care service.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities.

Why we carried out this inspection

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

We carried out inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act

2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People living in vulnerable circumstances

• People experiencing poor mental health (including people with dementia),

Before our inspection, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew, such as the local Clinical Commissioning Group (CCG). 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 carried out an announced inspection on 11 February 2015. During our inspection we spoke with a range of staff including GPs, the practice manager, nurse and reception staff. We observed how patients were communicated with and met with the chair of the Patient Participation Group (PPG), a group of patients registered with a practice who work with the practice to improve services and the quality of care. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients at both RJ Mitchell surgery locations.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a needle stick injury was reported as a significant event within the practice. Staff awareness of the incident was evident, staff training was reinforced, additional safeguards were implemented and these were reviewed.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last five years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda and a dedicated meeting was held following any significant event. The practice audited any significant event occurrences at least annually to review actions and learning points from past significant events and complaints. There was evidence that the practice had learned from these 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.

Staff used incident forms and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of a patient who required a referral for secondary care. We saw the measures implemented as a direct result of learning from this incident. Systems were put in place such as alerts/flags on patient records on the practice computer systems, the patients details were double checked when they booked in for their appointment and this was repeated with the clinical staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager and GPs to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at their practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 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, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. The policy details for the local authority were available on line with no physical copy for staff to access although the contact details for them were available for staff to access. The practice informed us they would ensure staff also had access to a paper copy.

The practice had appointed dedicated GPs 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 who these leads were 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 children subject to child protection plans. The practice was able to demonstrate how this system operated.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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 staff that provided a chaperone service to patients had received chaperone training. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

There were systems in place for identifying children and young people with a high number of A&E attendances and to follow up on children who persistently fail to attend appointments for example for childhood immunisations. The practice maintained a carers list and had systems in place to highlight vulnerable patients and patients with more complex needs for example, patients with co-morbidities or those requiring multiple medications.

GPs were aware to appropriately use the required codes on their electronic case management systems to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, the practice met on a monthly basis with the Clinical Commissioning Group (CCG) medicine management prescribing advisor, their work included medicine prescribing patterns, such as with the of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. The practice system demonstrated that 82% of patients who required a medicine review had received one and 96% of patients on more than four medicines had had a medicine review. The practice had also completed an audit on urinary tract infections including the practice use of medicines compared to the National Institute for Health and Care Excellence (NICE). NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. The GP demonstrated that they had attended the North Newcastle Locality Meeting in January 2015. The agenda of this meeting regularly included medicines optimisation updates. Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. When prescribers went on home visits before leaving the practice premises, they did not record the serial numbers of any prescription forms/ pads they were carrying. Blank prescription forms were otherwise handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and regular training updates. We saw evidence that the lead had carried out audits, the last one was completed in December 2014 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that findings of audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example,

personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There had been a needle stick injury and all staff were aware of the learning action points and had received update refresher training. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy dated 2015 for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and pulse oximeters.

Staffing and recruitment

Records we looked at contained evidence that the majority of the appropriate recruitment checks had been undertaken. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However a recent recruit had not been in receipt of criminal records checks through the Disclosure and Barring Service (DBS) prior to their employment. There were records which showed they had been subject to and received satisfactory DBS checks with their previous NHS employer. The practice manager demonstrated that it was discussed with staff in their January 2015 practice meeting that all staff would be subject to criminal records checks through the DBS, following a decision made by the GP partners and that these were in progress. Staff had photographic identity (ID) on their NHS access control Smartcard.; (Access control Smartcards are secure measures which are put in place to protect data. Access control means that only those people who are directly involved in your care, and have a legitimate reason to access medical information can do so). The practice manager was aware that staff recruitment records should include photographic ID.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within the weekly practice meetings. For example, the practice manager had shared the findings from an infection control audit with the team, when lighting in a waiting area used caused a complaint this was discussed and addressed as noted in the practice meeting minutes.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff gave us examples of referrals made for patients whose

Good

Are services safe?

health deteriorated suddenly, and one of the Care Quality Commission (CQC) comment card responses noted how quickly staff had appropriately responded to their deterioration in health. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made quickly to the GP so a child could be seen immediately or following their process for a call about an acutely ill child and informing parents about contacting the emergency service or attending A&E. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

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 (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of both practice sites and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia amongst other medicines to manage a range of emergencies. 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. 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. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were included. We saw an example of this with the cover provided for long term sickness and succession planning considerations were being made for staff who may retire and the mitigating actions that would be put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff informed us that practice meetings included information from new guidelines and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for a number of conditions. We saw that GPs attended locality meetings (local peer group meetings), where education was a standard agenda item. Our review of the meeting agenda confirmed that this happened.

The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within a period of time by their GP according to need, this was monitored and managed by the GPs. Should an older patient be discharged from hospital for example, the GP telephoned within 72 hours to ensure that they have necessary medication as well as the social care.

Older people with complex needs such as having a long term condition or those on multiple medicines had care plans in place. The patients with care plans had access to the practice and to their nominated GP by a separate telephone line. The GP informed us the separate line was responded to as soon as practicable.

All new-born babies were assessed within 72 hours of birth and were booked to have a six week child development check routinely. Immunisation clinics were provided and the practice had an open door policy for health visitors to come in to discuss children they had concerns with. The practice antenatal care was provided by the community midwives who attended the practice once every two weeks.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. 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.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the previous year. In each of these completed audits the practice was able to demonstrate the changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved resulting since the initial audit. An example included an audit for the improvement of recording of patients with depression. They found that by introducing a template as well as an assessment tool they improved their recording, which in turn led to improved depression management and care. As a result of the re-audit, the practice kept the template as a tool for recording depressive illness as well as the assessment form. The results were presented at a practice meeting.

The practice collected information for the Quality Outcomes Framework (QOF) and reviewed performance against national screening programmes to monitor

Good

Are services effective?

(for example, treatment is effective)

outcomes for patients. Quality and Outcomes Framework (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 practice demonstrated that 96% of patients on four or medicines had been in receipt of a medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and childhood immunisations. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, staff meetings and peer support to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all GPs should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

Effective staffing

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 and one GP had completed a minor operations course. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the nurse informed us that they had taken on the role of lead nurse for asthma care and had received training to support her in this role.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology Those with extended roles saw patients with long-term conditions such as asthma, COPD and diabetes; they were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice manager described that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's' 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 out of hours service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and

decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Patients who resided in care homes were visited by the GP either on request or as part of their medicine review or care plan reviews. The practice had meetings with the Integrated Local Care Team (ILCT), made up of nurses, community matron and a social worker every three months. The ILCT regularly monitored patients with long-term conditions, patients who were vulnerable and those with poor mental health, including patients with dementia. The practice was able to add new patients to the ILCT list that required nursing or social input, or had the option of referring patients to the community matron. They described a good working relationship with the district nursing team and that this positive relationship and effective communication improved the monitoring and management of patients in their care.

We saw that any patients who deliberately self-harmed were identified from A&E discharges and were invited for mental health assessment and support. These patients were highlighted on the practice computer system. As part of the practice's innovation to improve services for their patients, a mental health counsellor had a weekly surgery to support people with poor mental health.

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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice used the Special Patient Register to communicate special patients' notes which enable information to be shared regarding patients who require specific clinical care management during the out-of-hours period when the usual pathways of care maybe not be accessible or available. This person specific information enabled continuity of care for patients for example with a terminal illness, complex mental health concerns or those who have in place any advance care instructions such as do not attempt to resuscitate, or information that would help the attending doctor such as a medication regime.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Staff had received specific Mental Capacity Act 2005 training in 2013 and consent in general practice training. The practice had not needed to use restraint but staff were aware of the distinction between lawful and unlawful restraint. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders (DNACPR). This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. The practice scanned the DNACPR documentation onto the appropriate patient records and highlighted the date set for this documentation to be reviewed.

The practice maintained records of the patients with a learning disability and those with dementia and used a read code system to record details of their carers or people involved in supporting them. Patients were also supported to make decisions through the use of care plans, which they or their family/carers or advocate were involved in agreeing. There were only a small number of patients in either of these groups and those registered at the practice were well known to staff.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not

Good

Are services effective?

(for example, treatment is effective)

have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GPs and nurses documented consent in the patient record as a practice policy for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

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 and they were offered an annual physical health check. Practice records showed they had all received a check up in the last 12 months.

The practice's performance for cervical smear uptake was comparable to others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the CCG average, and again there was a clear policy for following up non-attenders by the practice nurse.

A register was kept of patients who were identified as being at high risk of admission. Palliative care patients had up to date care plans in place. Ninety-six percent of patients received annual medication reviews for polypharmacy (multiple medicines). There was evidence of multidisciplinary case management meetings and provision of a named GP for patients over 75.

The practice informed us that they documented health promotion and lifestyle advice in the notes as did the GPs. We saw that the practice held a register of those in various vulnerable groups (e.g. homeless, travellers, learning disabilities). There was evidence from patients that they had been signposted to various appropriate support groups and been offered information and advice.

We saw for example that any patients who deliberately self harmed were identified from A&E discharges and were invited for mental health assessment and management. A mental health counsellor held a weekly surgery at the practice to support patients with poor mental health.

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 patient survey 2015. The evidence from this source showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The survey found that 84% of patients said the last GP they saw or spoke to was good at treating them with care and concern, 92% had confidence and trust in the last GP they saw or spoke to.

Eighty-six percent said the last GP they saw or spoke to was good at giving them enough time. The survey found that 96% of patients said the last nurse they saw or spoke to was good at listening to them and at giving them enough time.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 65 completed cards and the majority were positive about the service experienced. Twenty-six of the 65 patients said the service was excellent or very good and 38 patients said that the service was good. Patients said they felt the practice staff were professional, efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive about being listened to; this was not a common theme although the anonymised comment was fed back to the practice. We also spoke with three patients on the day of our inspection, they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this would help them diffuse potentially difficult situations.

People whose circumstances may make them vulnerable, such as homeless patients could access the practice without fear of stigma or prejudice. However the practice staff could not recall any event when a patient, who was homeless, had needed to register at the practice.

Care planning and involvement in decisions about care and treatment

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, data from the national patient survey showed 79% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were comparable to the local Clinical Commissioning Group (CCG) average.

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

Staff told us that translation services were available for patients who did not have English as a first language. The practice found they had very few patients to which there were language barriers, the GPs spoke Urdu, Punjabi, Gujarati and Bengali.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The national GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 86% said the last GP they saw or spoke to was good at explaining tests and treatments. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients found that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. This was set up by the Patient Participation Group (PPG). The practice's computer system alerted GPs if a patient was also a carer. One staff member had also completed carer awareness training. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. As part of the practices innovation to improve services for their patients, a mental health counsellor held a weekly surgery to support people with poor mental health.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of locality meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population, such as the monitoring of unplanned A&E admissions.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG).For example, all same day appointments commenced at 8.30am to allow the same access to patients whether booking in person or over the telephone. Patients found that as the practice opened at 8am patients were booking appointments in person at the practice prior to the telephones being switched from the out-of-hours service. Notices were put in the waiting rooms to inform patients that the GPs took telephone consultations after morning surgery each day and that the practice did not close at lunchtime.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Examples of this included patients with a learning disability, those unemployed and carers.

The practice had access to telephone translation services and GPs who between them spoke in addition to English, four languages.

The premises were accessible at both practice locations to wheelchair users with ramps, consultation/treatment rooms and toilets available on the ground floor. The doors were not automated and patients may require support from staff or carers. The practice said they would consider whether to make applications for funds towards improving the access to adapt the premises further to meet the needs of patient with disabilities.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

RJ Mitchell Medical Centre opening times were Monday's 8am to 7.30pm, Tuesday to Friday 8am to 6.30pm with the exception of Thursdays when the surgery times were 8am to-1pm at the Waterhayes Surgery and 8am to 1pm at the RJ Mitchell Medical Centre, Talke. The practice did not close at lunchtime.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients registered at the practice who resided in local care homes by a named GP, and to those patients who needed one.

Patients were in general satisfied with the appointments system. Of the 65 Care Quality Commission (CQC) comment cards five patients said they had experienced difficulties getting through to the RJ Mitchell practice location by telephone to make an appointment. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. The Patient Participation Group (PPG) had conducted a patient survey in March 2014 regarding telephone access at the practice with questions focused on the area of appointment bookings, as this had been highlighted as a source of concern. The PPG sent out 150 questionnaires for patients to complete, 130 were returned. The PPG reported their findings to the practice manager and service improvements were made and

Good

Are services responsive to people's needs?

(for example, to feedback?)

continue to be monitored by the practice and PPG. As a result of the survey the practice instigated a number of measures to improve the service. These included; notices requesting that patients to ring after 11am for test results or hospital letters, waiting room notices to inform patients that the GPs completed telephone consultations after morning surgery each day and adverts highlighting that the practice did not close at lunchtime and they had an evening surgery every Monday.

The practice's extended opening hours on Mondays were particularly useful to patients with work commitments. For older patients and those with long-term conditions the practice offered longer appointments when needed and patients with care plans had access to a separate telephone line. Appointments were available outside of school hours for children and young people and the premises were suitable although there was no specific baby changing room facility there was a baby changing mat available. Online booking system once registered onto the system was available and easy to use. GPs offered telephone consultations where appropriate.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the form of the practice summary leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three of the five complaints received in the last 12 months and found they had been acknowledged, investigated and dealt with in a timely way following their complaints process.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and shared with staff to improve the practice. For example practices such as alerts on records of patients who have similar names and dates of birth to reduce the risk of miscommunication.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy, although the practice did not have a written business plan. The practice vision and values included to offer a local, caring, good quality service that was accessible to all patients.

We spoke with eight members of staff and they all knew and understood the practice vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

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

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported, said they worked as a team and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. Quality and Outcomes Framework (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 weekly practice meetings and action plans were produced to maintain or improve outcomes.

The practice in line with professional requirements had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held weekly partners meetings, monthly locality group meetings with neighbouring practices, quarterly full practice meeting where significant events and complaints as well as organisational and management issues were reviewed and discussed. The practice manager generally attended the six weekly Patient Participation Group (PPG) meetings, although the GPs advised they would attend when able. Every three months the practice attended the Integrated Local Care Team (ILCT) meetings, made up of nurses, community matron and social workers. We looked at minutes from the various meetings and found that performance, quality and risks were discussed.

Leadership, openness and transparency

We saw from minutes that whole team meetings with staff from both practice locations were held regularly, at least quarterly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team had half day events were training and education was planned.

The practice manager and partners were responsible for human resource policies and procedures. There were a number of policies in place to support staff which included recruitment policy, disciplinary procedures and management of sickness. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the PPG, comments, complaints, the national GP survey and patient questionnaires. A PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are taken into consideration and to work in partnership with the surgery to improve common understanding. The practice had an active Patient Participation Group (PPG) which has a stable group of members. The PPG included representatives from various population groups including a younger person; however the PPG chair informed us that it had proved difficult to recruit younger members. They had tried varying the times of meetings to encourage patients of working age to participate. The PPG had carried out

Are services well-led?

Good

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

regular surveys some of which were focused, for example they completed a survey on telephone access based on patient feedback and they met with the practice every six weeks, ordinarily. The PPG also produced an annual report to the practice of their findings and reported on the practices responses actions and implementation of any changes or improvements. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice PPG website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice manager informed us they had a whistleblowing policy which was available to all staff within 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 five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. An example of this included a needle stick injury which had resulted in improved policies and procedures.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.