Bridgeway Practice

Quality Report

Meadows Health Centre, 1 Bridgeway Centre, The Meadows, Nottingham, NG2 2JG
Tel: 0115 986 1128
Website: www.bridgewaypractice.co.uk

Date of inspection visit: 1 June 2015
Date of publication: 23/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bridgeway Practice on 1 June 2015. Overall the practice is rated as good.

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

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

Comments from patients were generally very positive about the care and services they received. They said that they were treated with kindness, dignity and respect and were involved in decisions about their care and treatment.

Patients had access to care and treatment when they needed it. They told us they were usually able to access an urgent appointment or request a telephone consultation the same day. Three patients reported a delay at times in obtaining a non-urgent appointment.

Overall, systems were in place to keep patients safe and to protect them from harm. However, robust recruitment procedures were not followed to ensure that all staff employed are suitable to carry out the duties required of them.

The staff team were committed to meeting patients' diverse needs. Patients' needs were assessed and care and treatment was planned and delivered following best practice guidance.

Staff were supported to develop their knowledge and acquire new skills to provide high quality care.

There was an open, positive and supportive culture. The staff team were committed to new ways of working to ensure the service was well-led.

Summary of findings

The practice had undergone considerable changes following the recent merger of the partnership with another GP practice. The leadership and systems to drive improvements and monitor the quality of service were being strengthened, to ensure the delivery of high-quality care.

There were plans to further develop the services but this was dependent on the recruitment of additional clinical staff, and alterations to the premises, to provide further space and consultation rooms. A date for starting the alterations had yet to be agreed.

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

Importantly the provider must:

Operate effective recruitment procedures to ensure the information required by law is available in relation to all staff employed, to ensure they are fit to carry out the duties required of them.

The provider should:

Strengthen the systems in place to support staff to deliver care and treatment to expected standards by;

- developing the induction programme relevant to specific staff roles
- providing appropriate clinical supervision to the nurse and ensuring all staff receive a regular appraisal of their performance.
- reviewing the numbers, skills and experience of staff required to further develop the services and meet patients' needs.

Ensure that information available to patients enables them to understand the complaints process.

Develop a vision and future plans for the practice to give all practice staff a clear direction for improvement.

Review relevant policies including infection control and staff recruitment to include all procedures followed at the practice.

Ensure a robust clinical audit programme is in place to provide assurances that patients are receiving effective care and treatment and to improve patient outcomes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Systems were in place to ensure that the practice was clean and adequately maintained. The practice was open and transparent when things went wrong. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, and addressed. Learning took place and appropriate action was taken to minimise incidents and risks.

Overall, systems were in place to keep patients safe and to protect them from harm. However, effective recruitment procedures were not followed to ensure the information required by law was available in relation to all staff employed, to ensure they are suitable to carry out the duties required of them.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff worked closely with other providers to meet patients' needs. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. There were opportunities to discuss new guidelines and agree changes to practice, as regular clinical meetings were held. Robust clinical audits hadn't been completed in the last twelve months, due to changes to the partnership. The GPs planned to put a robust audit programme in place to provide assurances that patients were receiving effective care and treatment, and to improve outcomes where needed.

The capacity of the clinical staff to provide effective services was limited, due to the recent increase in the number of patients registered with the practice. The practice was actively looking to recruit another GP and practice nurse, to further develop the services and meet patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients described the staff as friendly and caring, and said they were treated with dignity and respect. Patients were involved in decisions about their care and treatment, and their wishes were respected. Staff supported patients to cope emotionally with their health and conditions. We observed that patients' privacy, dignity and confidentially were maintained. Staff were caring, respectful and polite when dealing with patients.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The services were flexible and were planned and delivered in a way that met the needs of the local population. Patients told us that the practice was responsive to their needs, as they were able to access care and treatment when they needed it. They described their experience of making an appointment as generally good, as they were usually able to make an urgent appointment or request a telephone consultation the same day.

There was a culture of openness and people were encouraged to raise concerns. Patients' concerns and complaints were listened to and acted on to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice was undergoing a settling period following recent changes to the partnership and senior managers. The systems to drive improvements and monitor the services were being strengthened, to ensure the delivery of high-quality care and there was a genuine commitment from the partners and practice staff to improve. Staff were starting to take on lead roles within the team, although this was in the early stages of development.

In view of the above changes, patients had not been issued a recent satisfaction survey to obtain their views. There were plans to issue a survey by December 2015. A Patient Participation Group (PPG) had recently re-formed to work with the practice staff, to represent the interests and views of patients to improve the service.

There was an open, positive and supportive culture. Staff said that they felt valued, well supported, and involved in decisions about the practice. They were supported to acquire new skills to ensure high quality care. The staff team were committed to new ways of working to ensure the service was well-led.

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. Patients over 75 years were invited to attend an annual health check, and had a named GP to ensure their needs were being met. The practice worked closely with other services to enable patients to remain at home, where possible. The practice was signed up to an enhanced service to avoid unplanned admissions into hospital, and had identified older patients who were at risk of admissions. Care plans had been developed for such patients, which were kept under review.

Flu, pneumococcal and shingles immunisations were actively offered to patients. It was responsive to the needs of older people, and offered home visits to patients unable to attend the practice. Carers were identified and supported to care for older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The nurse had lead roles in chronic disease management and patient reviews. Patients were offered an annual health review including a review of their medicines. They also had a named GP to ensure their needs were being met. When needed, longer appointments and home visits were available. Patients with long term conditions and other needs were reviewed at a single appointment where possible, rather than having to attend various reviews.

Patients were educated and supported to self-manage their conditions. The practice kept a register of patients with complex needs requiring additional support, and worked with relevant professionals to meet their need. Carers were identified and supported to care for people with complex long-term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Priority was given to appointment requests for babies and young children. Systems were in place for identifying and following-up children at risk of abuse, or living in disadvantaged circumstances. The practice worked in partnership with midwives, health visitors and school nurses to meet patients' needs. The 2013 to 2014 data for all childhood immunisations showed that most standard immunisation rates for children up to 2 years of age were

Summary of findings

good, although several immunisation rates for pre-school aged children were below the local Clinical Commissioning Group average. A robust action plan had been put in place to bring about the necessary improvements.

Children were able to attend appointments outside of school hours. The practice provided maternity care and certain family planning services. The practice also provided advice on sexual health for teenagers.

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). Patients were offered telephone consultations and were able to book non-urgent appointments around their working day by telephone or on line. Extended appointment hours were offered until 7.45 pm on Monday, which was helpful for patients of working age. The practice offered a 'choose and book' service for patients referred to secondary services. This provided greater flexibility over when and where their test took place, and enabled patients to book their own appointments.

NHS health checks were offered to patients aged 40 to 74 years, which included essential health checks and screening for certain conditions. The practice also offered health promotion and screening appropriate to the needs of this age group

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 people with learning disabilities. Patients were offered extended or same day appointments or telephone consultations. Several appointments were made available each day specifically for vulnerable patients or those at risk of admission to hospital. Patients were also invited to attend an annual health review, and had an allocated GP to ensure their needs were being met.

The practice worked with relevant services to ensure vulnerable people received appropriate care and support. Patients were told about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of patients experiencing poor mental health. Patients were offered extended or same day appointments or telephone consultations. When needed, longer appointments and home visits were available. Patients were invited to attend an annual health review, and had an allocated GP to ensure their needs were being met. The practice worked with mental health services to ensure that appropriate risk assessments and care plans were in place, and that patients' needs were regularly reviewed.

Patients were supported to access emergency care and treatment when experiencing a mental health crisis. The practice was signed up to provide enhanced services for patients with dementia, and screened patients to help facilitate early referral and diagnosis where dementia was indicated.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 29 completed cards. All comments were very positive about the care and services patients received. Six patients referred to the service and treatment they received as excellent. Patients described the staff as polite, caring, helpful and respectful. Several patients commented that the practice was always clean and hygienic.

We also spoke with nine patients during our inspection. All patients told us they were treated with dignity and respect and were generally very satisfied with the care and treatment they received. They also thought the staff were approachable and caring, and felt listened to.

Several patients told us that the appointment system and telephone access to the practice had improved. Patients were usually able to make an urgent appointment or request a telephone consultation the same day. They could also book a non-urgent appointment two weeks in advance. Three patients said that it could take five to ten days to get a non-urgent appointment.

In view of the recent changes to the partnership and senior managers, patients had not been issued a recent satisfaction survey to obtain their views. A Patient Participation Group (PPG) had recently re-formed. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We spoke with two representatives from the PPG. They told us they felt supported in their role, to represent the views of patients to improve the service.

The most recent data available for the practice on patient satisfaction included the 2015 national patient survey, which 85 patients completed. This showed that patients were treated with dignity and respect, and were generally satisfied with the care and treatment they received.

We also reviewed patient reviews of the practice on NHS Choices completed in the last six months. Three positive comments referred to the doctors as good and the reception staff being helpful. Five negative comments related to telephone access, disrespectful reception staff, access to non–urgent appointments and a patient's treatment. The practice manager assured us that action had been taken to address these issues.

Areas for improvement

Action the service MUST take to improve

Operate effective recruitment procedures to ensure the information required by law is available in relation to all staff employed, to ensure they are fit to carry out the duties required of them.

Action the service SHOULD take to improve

Strengthen the systems in place to support staff to deliver care and treatment to expected standards by;

- developing the induction programme relevant to specific staff roles
- providing appropriate clinical supervision to the nurse and ensuring all staff receive a regular appraisal of their performance.
- reviewing the numbers, skills and experience of staff required to further develop the services and meet patients' needs.

Ensure that information available to patients enables them to understand the complaints process.

Develop a vision and future plans for the practice to give all practice staff a clear direction for improvement.

Review relevant policies including infection control and staff recruitment to include all procedures followed at the practice.

Ensure a robust clinical audit programme is in place to provide assurances that patients are receiving effective care and treatment, and to improve patient outcomes.

Bridgeway Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP and a practice manager.

Background to Bridgeway Practice

Bridgeway Practice is a partnership between three GPs providing primary medical services to approximately 4,900 patients. The practice is located in the Meadows health centre, south of Nottingham city centre. The Meadows is an area of high social deprivation. The practice population includes patients from various ethnic groups.

The practice merged with another GP practice in October 2014, resulting in some changes to the clinical team. The practice has three GP partners one of which is female, a practice nurse and a health care assistant. The clinical team are supported by the practice manager and an administrative team including reception staff. There are 2.5 whole time equivalent GPs working at the practice, in addition there are one whole time nursing staff and 0.92 health care assistant.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services. The practice is also contracted to provide a number of enhanced services, which aim to provide patients with greater access to care and treatment on site.

The practice is open between 8.30am and 6.30 pm Monday, Tuesday, Wednesday and Friday, and from 8.30 am to 12.30pm on Thursday. Extended appointment hours are offered until 7.45 pm on Monday.

The practice does not provide out-of-hours services to the patients registered there. These services are provided by NEMS Community Benefit Services Limited. Contact is via the NHS 111 telephone number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This inspection was planned to check whether the provider was 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, we always ask the following five questions of every service and provider:

- 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:

Detailed findings

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also obtained feedback from three external professionals who worked closely with the practice, including a health visitor, district nurse and a learning disability health facilitator.

We carried out an announced visit on 1 June 2015. During our visit we checked the premises and the practice's records. We spoke with various staff including a practice nurse, a healthcare assistant, three GPs, reception and administrative staff and the practice manager. We also received comment cards we had left for patients to complete and spoke with patients and representatives who used the service

Requires improvement

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. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff had raised concerns about a child's welfare with the relevant agencies. Following the incident, the practice changed their registration process to help keep patients safe.

A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken. Records showed that safety incidents and concerns were appropriately dealt with. They also told us alerts were discussed at practice meetings to ensure all staff were aware of issues relevant to the practice, and where they needed to take action.

We reviewed safety records and incident reports for the last two years. This showed the practice had managed these consistently over time, and so could evidence a safe track record.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. Records showed that patients received an apology when mistakes occurred. A system was in place for reporting, recording, investigating and monitoring significant events and incidents.

Records were available of incidents that had occurred during the last four years. We looked at seven recent significant incidents. These were completed in a timely way, and included a summary of action taken to avoid re-occurrences and lessons learnt.

Discussions with staff and records we looked at showed that the findings and learning from significant incidents were shared with staff at team meetings, and that appropriate learning and improvements had taken place. For example, one significant incident involved changes to a patient's medicines that had not been updated onto their medical records following their discharge from hospital. The systems were strengthened following the incident to ensure the on call GP checks all hospital discharge summaries, and updates any medicine changes onto the patients' records.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff we spoke with said that they had received recent safeguarding training specific to their role. For example, the GPs had completed level three children's training and vulnerable adults training. The practice manager was updating the training matrix and files to show that all staff had received appropriate training.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children, and who to speak to in the practice if they had a safeguarding concern. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Contact details were available to staff.

One of the GPs was the lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. We checked the records relating to five safeguarding issues. These showed that the practice had liaised with relevant professionals and agencies to share essential information about vulnerable patients. Staff had recorded information about patient's welfare in their electronic record.

Records showed that monthly multi-disciplinary safeguarding meetings were held, to share information and discuss children and adults who were at risk of harm.

A system was in place to highlight vulnerable patients on the practice's electronic records, and to ensure that risks to children and young people were clearly flagged and reviewed. The alert system ensured they were clearly identified and reviewed, and that staff were aware of any relevant issues when a patient or their next of kin attended appointments or contacted the practice.

Patients' individual records were managed in a way to keep people safe. All information about the patient were kept on the electronic system.

A chaperone leaflet was visible to patients on the practice's web site and at the surgery. (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**)**. The nurse and health care assistant at the practice had been trained to be a chaperone. Records showed that they had a satisfactory disclosure and barring (DBS) check. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children. Staff we spoke with were aware of their responsibilities, including where to stand to be able to observe the examination.

Several non-clinical staff had also received chaperone training with a view to undertaking this role in the future. The provider's DBS policy stated that a DBS check was undertaken on all staff. However, we found that the policy was not being followed, as a DBS check was not routinely obtained for all non-clinical staff.

Records showed that a DBS risk assessment had been completed for non-clinical staff. The risk assessment form was not robust. It asked staff to confirm if they had a criminal record, but did not cover cautions, reprimands, warnings, or if they were on the Adult's and Children's Barred List to help determine their suitability to work with vulnerable people. The practice manager agreed to update the form and the DBS policy.

Medicines management

Several patients told us that the system for obtaining repeat prescriptions generally worked well, to enable them to obtain further supplies of medicines.

Procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, regular checks were carried out to ensure that medicines including vaccines were within their expiry date and suitable for use. All the medicines we checked were in date. Expired and unwanted medicines were disposed of in line with waste regulations.

We checked medicines stored in the treatment rooms including the medicine refrigerators. We found that medicines were stored securely and managed appropriately, and were accessible only to authorised staff.

A policy was in place 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. An electronic data logger recorded the temperature of the vaccine refrigerators, which staff monitored. Staff also manually checked the temperatures each day as a further assurance the medicines were kept at the required temperatures.

The nurse administered vaccines using directions that had been produced in line with national guidance. We saw evidence that the nurse had received appropriate training to administer vaccines.

All prescriptions were checked and signed by a GP before they were given to the patient. The arrangements in place to ensure the security of blank prescription forms were being strengthened, to ensure they were tracked through the practice and kept securely at all times.

A system was in place to oversee the management of high risk medicines, which included regular monitoring in line with national guidance. We checked the records of three patients who were prescribed a high risk medicine. The records showed that they had received appropriate blood tests and monitoring, to ensure that their medicines were managed safely.

The practice worked with the Clinical Commissioning Group (CCG) medicines team, to ensure that medicines were managed safely. The medicines team carried out regular audits, to check that patients' medicines were prescribed appropriately.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged and reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

We observed the premises to be clean and tidy. Appropriate hand washing facilities were available for staff and patients, and notices about hand hygiene were displayed. Cleaning schedules were in place and records were kept, to ensure the practice was clean and hygienic.

We saw that various audits had been completed to monitor the standard of cleanliness, and ensure that appropriate practices were being followed. The cleaning provider carried out an audit every three months. The last

completed audit dated February 2015 recorded an overall score of 97%. The practice nurse completed a weekly audit. Recent audits highlighted no issues in regards to the standards of cleanliness and infection control.

An external provider had also completed a comprehensive infection control audit in November 2014, which identified various areas requiring improvement. A further audit was completed in April 2015. This showed that the areas requiring improvement from the previous audit had been addressed; the practice achieved compliance in all areas.

The practice had a number of policies to enable staff to apply infection control measures. We noted that several policies applied to Nottingham City Care provider, and had not been adapted to reflect all procedures followed at the practice. The practice manager agreed to address this issue.

The practice manager planned to put a comprehensive induction programme in place for new staff, which will include relevant training on infection control. Staff we spoke with told us that they received recent on-line training on infection control. Records we looked at supported this. The nurse and practice manager had recently taken on the lead for infection control. They planned to undertake further training to undertake this role.

The Hepatitis B policy stated that any offer of employment involving exposure prone procedures (EPP) would be subject to medical clearance including Hepatitis B immunity. This mainly related to clinical staff. Records were not available to show that all relevant staff were protected from Hepatitis B, where required. Following the inspection, the practice manager assured us that she was obtaining records to provide evidence of this. We were unable to verify this.

The health centre had a policy for the testing and management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records were kept to show that control measures and regular checks were carried out in line with the policy, to reduce the risk of legionella infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly, and we saw records that supported this. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the defibrillator (used to attempt to restart a person's heart in an emergency).

Staffing and recruitment

The recruitment policy in place was brief and did not set out all the standards the practice followed when recruiting new staff. Following the inspection, we received an updated policy that generally detailed the various stages of the process and information required by law.

We reviewed the personal files of two staff recruited in the last 14 months, one of which was appointed since the partnership changed in October 2014. Robust recruitment procedures were generally followed in practice. However, the files did not contain all appropriate checks and information required by law, prior to staff commencing employment, to ensure they were suitable to work with vulnerable adults or children. For example, the files did not contain satisfactory information about any physical or mental health conditions, which are relevant to the person's ability to carry out their work.

One file did not include a completed application form or a copy of the person's curriculum vitae (CV) to support their suitability to work at the practice. We were therefore unable to determine if a full employment history had been obtained. The practice manager assured us the information was available electronically. We were unable to verify this.

Both staff files contained one satisfactory reference from their previous employer/line manager. The recruitment policy stated that all jobs were subject to satisfactory references, but did not state how many references were obtained and from whom, to provide evidence of conduct in previous employment, including working in health or social care or with children or vulnerable adults.

Staff told us that they had attended an interview to support their suitability to work at the practice. However, the files did not contain a summary of the interviews, to show that robust and fair procedures were followed.

Following the inspection, we received assurances that the above staff files had been updated to include the required information. We were unable to independently verify this. We will review recruitment procedures at the next inspection.

Requires improvement

Are services safe?

A policy was in place for checking nurses and GPs qualifications and registration to practice. However, records were not available to show these appropriate on-line checks had been carried out, to ensure that the nurse and GPs were registered to practice with their relevant professional bodies. The practice manager assured us that she had recently carried out the above checks.

She agreed to strengthen the systems in place to ensure that all clinicians remained registered to practice.

Monitoring safety and responding to risk

Overall, systems and policies were in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, equipment, staffing, dealing with emergencies and the management of medicines.

Records showed that essential health and safety checks were carried out. For example, the fire alarm system was regularly serviced to ensure it worked properly. Records also showed that all equipment was regularly tested to ensure it was safe to use, and that the premises were appropriately maintained.

The practice also had a health and safety policy, which staff had access to. There was an identified health and safety representative.

The practice had not completed a risk log assessing the level of risk and actions required to reduce and manage certain risks. For example, risks associated with staff changes, the delay in internal building changes and the ability to recruit further clinical staff, which may impact on the ability to deliver services to patients. The practice manager agreed to address this.

The staff we spoke with were aware of the procedure in place at the practice if a patient, visitor or member of staff was taken unwell suddenly, and for identifying acutely ill children to ensure they were seen urgently. Staff gave examples of how they enabled patients experiencing a mental health crisis, to access urgent care and treatment. The practice also monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had the following arrangements in place to manage emergencies. Staff we spoke with told us they had received recent training in basic life support. The practice manager was updating the training matrix and files to show that all staff had received the training.

We saw that 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). Processes were in place to ensure the equipment was tested and maintained regularly.

Emergency medicines were also available in a secure area of the practice and all staff knew of their location. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The emergency medicines included those for the treatment of common cardiac conditions, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). The practice did not routinely hold stocks of medicines for the treatment of other emergencies. The reason for this was the practice would dial 999 and call an ambulance. Clinical staff assured us that a risk assessment had been completed, and a protocol was in place to manage this. We did not see records to verify this.

The practice manager planned to update the business continuity plan to deal with various emergencies that may impact on the daily operation of the practice, to include all risks and actions to reduce and manage these.

A fire risk assessment had been carried out, which included actions required to maintain fire safety. Staff we spoke with told us they had received recent training, and that they practised regular fire drills to ensure they knew the procedure in the event of a fire. The practice manager was updating the training matrix and files to show that all staff were up-to-date with the training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Completed comment cards and patients we spoke with told us they received appropriate care and treatment. Patients said they were referred appropriately to other services when needed

The GPs and practice nurse could 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 told us there were opportunities to discuss new guidelines and agree changes to practice at clinical meetings, which were held every two months. Minutes of meetings supported this.

The clinical staff told us they worked together, to ensure a consistent and effective approach to meeting patients' needs. They worked closely with local services and other providers to meet patients' needs. They described how they completed thorough assessments of patients' needs, and provided care and treatment in line with NICE guidelines.

The clinical staff also explained how patients were reviewed regularly to ensure their treatment remained effective. For example, patients with diabetes received regular health checks and were referred to other services where required.

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.

Management, monitoring and improving outcomes for people

The GPs told us that opportunities to develop clinical lead roles had been limited in the last 12 months in view of staff changes. One of the GPs was the lead in diabetes and was accessing specialist training to undertake this role. All three GPs and the nurse were looking to take on further lead roles, which would enable the practice to focus on specific conditions and improve outcomes for patients.

The GPs acknowledged that robust clinical audits hadn't been completed due to changes to the partnership. We were shown four quality improvement plans that had been completed in the last 12 months, to measure the effectiveness of patients care and treatment. None of these were a completed review cycle, where the practice was able to demonstrate the full extent of changes following the initial findings. A complete clinical audit programme wasn't in place, to provide assurances that patients were receiving the right care and treatment, and to improve patient outcomes. The GPs agreed to put a programme in place for 2015/2016, linked to data sources and incidents to identify areas where improvements were needed.

Various staff had key roles in monitoring QOF (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The QOF performance data for 2013 to 2014 showed that the practice achieved a total of 87.5% in respect of their performance in measuring national clinical indicators, which was below the national average of 93.5%. The practice performance was above the national and local average in 10 out of the 19 clinical areas assessed.

This practice was an outlier for the following clinical targets:

- Diabetes performance indicators were below the national average.
- The percentage of women aged 25 to 65 years who had received a cervical screening test performed in the preceding five years, was significantly lower than the national average.

The practice was aware of the areas where performance was below local and national averages. We saw that robust action plans were in place to bring about the necessary improvements.

The practice's prescribing rates were similar to local and national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP, and that the latest prescribing guidance was being used.

Effective staffing

Several staff had worked at the practice for a number of years, which ensured continuity of care and services for

Good

Are services effective?

(for example, treatment is effective)

patients. The GP and nursing cover was provided by regular staff. The number of patients registered with the surgery had increased from 2,700 to 4,900 patients, following the merger with another GP practice in October 2014.

There had been some increase to the whole time equivalent GPs working at the practice. However, the capacity and skill mix of staff had not increased to meet the current numbers of patients registered, and the increased demands on the service. In addition, one GP and the practice nurse were planning to reduce their weekly hours, which would further reduce the capacity of clinical staff to provide effective services.

The GP partners assured us that they were actively looking to recruit another part-time practice nurse and salaried GP, to further develop the services and meet patients' needs.

A new member of staff told us they had received appropriate induction training to enable them to carry out their work. We noted that the induction checklist was brief and generic, and did not relate to specific roles to ensure that new staff received essential information to carry out their work. The practice manager agreed to review this.

Records showed that staff had attended various training relevant to their role. This included training the practice considered to be mandatory such as infection control, fire safety and basic life support. A monthly protected learning event was held, which staff were supported to attend.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the practice nurse and the health care assistant had recently completed training on spirometry (lung function tests), to develop their role and enable them to carry out the tests at the practice.

The practice nurse told us how she was supported to further develop her skills to meet patients' needs. such as administrating vaccines, cervical cytology and managing patients with long-term conditions, and was able to demonstrate that she had attended appropriate training and updates.

Staff told us that they received supervision through peer support and team meetings they attended. The GPs provided clinical support to the practice nurse. However, opportunities to receive on-going clinical supervision were limited, as the practice did not employ any other nurses.

The GPs demonstrated that they were up to date with their yearly professional development requirements, and 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

Our findings showed that the practice worked closely with other service providers and staff to meet patients' needs.

Records showed that the practice held monthly multi-disciplinary meetings, to discuss the needs of adults with complex needs or at risk of unplanned admissions to hospital. This helped to ensure that patients and families received co-ordinated care and support, which took account of their needs and wishes. The meetings were attended by district nurses, social workers, community matron, care-coordinator and other professionals involved in patients care.

The practice was applying the gold standards framework for end of life care. It had a palliative care register and held regular internal, as well as monthly multidisciplinary meetings to discuss and review the care and support needs of patients and their families. All relevant staff involved in their care including GPs and district nurses attended.

Monthly children's meetings were also held to discuss all patients in vulnerable circumstances and at risk of abuse. These meetings were attended by the practice's clinical staff and the health visitor.

The practice had signed up to the enhanced service to avoid unplanned admissions and to follow up patients discharged from hospital. Enhanced services are additional services provided by GPs to meet the needs of their patients.

It was clear from discussions with the clinical staff that considerable work went into supporting people to remain in their own home, and ensuring they received appropriate support on discharge from hospital. The health care assistant told us that she was responsible for phoning patients recently discharged from hospital, to check how they were and if they required more support.

Good

Are services effective?

(for example, treatment is effective)

The practice also worked closely with the out-of-hours service to ensure that staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid unnecessary admissions.

Information sharing

We saw there was a system for sharing appropriate information about patients with complex needs with the ambulance and out-of-hours provider, to enable essential information to be shared in a secure and timely manner. The practice used their electronic system to coordinate record and manage patients' care. All staff were trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference.

The practice received test results, letters and discharge summaries from the local hospitals and the out-of-hours services both electronically and by post.

A policy was in place outlining the responsibilities of relevant staff in passing on, reading and acting on any issues arising from communications with other providers. We saw that test results, information from the out-of-hours service and letters from the local hospitals including discharge summaries were promptly seen, coded and followed up by the GPs, where required.

Electronic systems were in place to enable referrals to other providers be made promptly. The practice was signed up to the electronic Summary Care Record, which provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment.

Clinical staff told us that they obtained patients' informal consent before they provided care or treatment. There was a policy for obtaining written consent for specific interventions such as minor surgical procedures, together with a record of the benefits and possible risks and complications of the treatment. This did not apply at the time of our inspection as the practice did not provide minor surgery.

Clinical staff were aware of the Mental Capacity Act 2005, and understood their duties in fulfilling it, and were able to describe how they implemented it in their practice. Records were not available to show that all staff had received relevant training to ensure they understood the key parts of the legislation, and how they applied this in their practice. The practice manager agreed to follow up this issue, to ensure that all staff received the training.

Staff told us that patients who lacked capacity with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing, where possible. Staff gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. We saw evidence of this in one person's medical notes we looked at, who had capacity issues.

Health promotion and prevention

Several patients we spoke with told us the GPs and nurse gave them advice and guidance about maintaining a healthy lifestyle. We saw that health promotion information was available to patients and carers on the practice's website, and the noticeboards in the waiting area.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was promptly informed of all health concerns detected and these were followed up in a timely way. For example, a new patient had attended a health check on the day of the inspection. Their blood pressure was found to be high, and the GP was informed of this. The patient was given an appointment to see a GP the following day, to review their blood pressure and health.

We found that patients were educated and supported to self-manage their conditions, to improve their compliance and live healthier lives.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. In view of the recent merger of the partnership with another GP practice, accurate data was not available to confirm the actual percentage of patients in this age group, who had taken up the offer of the health check. The practice data showed that 22 patients had attended a health check from 1 October 2014 to 1 June 2015. The health care assistant had undertaken an audit to identify patients that had not attended a health check, and they were being sent an invite to attend.

The practice had various ways of identifying patients who needed additional support. The practice kept a register of

Good

Are services effective?

(for example, treatment is effective)

patients with a learning disability, those experiencing poor mental health, those in vulnerable circumstances, those with long term conditions and older people. They were offered an annual health check, including a review of their medicines.

In view of the recent merger of the partnership with another GP practice, accurate data was not available to confirm the actual percentage of patients who had taken up the annual health check. The practice showed that 65 patients were registered with poor mental health. Of these, 14 were offered and had received an annual health check since October 2014.

The practice had a higher percentage of patients with poor mental health. The practice worked with local mental health teams, counsellors and therapists to support patients' needs. The GPs told us that the mental health crisis team did not always provide timely assessments of patients, where needed. They had raised this with the Clinical Commissioning Group (CCG) as an issue.

Mental health counsellors held weekly clinics at the health centre for patients. A self-referral service was available to enable patients to access the service directly, which the CCG had initiated.

The practice screened appropriate patients for dementia, to support early referral and diagnosis where dementia was indicated.

The practice was involved in various screening programmes including bowel, breast and cervical screening. Data showed that the update on cancer screening tests was low in all areas, particularly cervical cytology and breast screening. We saw evidence that robust action plans had been put in place to address this. The practice data showed that there were already some improvements; for example the cervical cytology screening rate was up from 63% in April 2014 to 73% in June 2015.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013 to 2014 data for all childhood immunisations showed that most standard immunisation rates for children up to 2 years of age were good, although several immunisation rates for pre-school aged children were below the local CCG average. For example, 79.4% of patients had received the meningitis C booster, compared to the local average of 92.5%. An action plan including a new recall system had been put in place, to help improve the immunisation rates.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us the staff were friendly and caring and treated them with dignity and respect. They also said that they felt listened to and that their views and wishes were respected.

Staff and patients told us that consultations and treatments were carried out in the privacy of a suitable room. We noted that conversations could not be overheard. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. Confidential information was kept private.

The most recent data available for the practice on patient satisfaction included the 2015 national patient survey, which 85 patients completed. This showed that patients were treated with dignity and respect, and were generally satisfied with the care and treatment they received. For example, 88 % of people who completed the survey had confidence and trust in the last GP they saw or spoke to. Also, 72% said that the GP was good at treating them with care and concern and 80% said that they were good at listening to them. Their satisfaction in these areas when they saw a nurse was higher.

The above results with the exception of one were higher that the local Clinical Commissioning Group (CCG) average. The following results were lower that the local CCG average: 73% said the last nurse they saw or spoke to was good at explaining tests and treatments, and 59% said that they would recommend this surgery to someone new to the area.

We also reviewed patient reviews of the practice on NHS Choices completed in the last six months. Three positive comments referred to the doctors as good and the reception staff being helpful. Five negative comments related to telephone access, disrespectful reception staff, access to non–urgent appointments and a patient's treatment. The practice manager assured us that action had been taken to address these issues.

A notice was displayed in the patient reception area stating the practice's zero tolerance for abusive behaviour. 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.

Care planning and involvement in decisions about care and treatment

Patients told us they were supported to make decisions about their care and treatment. They were given sufficient time and information during consultations to enable them to make informed choices.

We looked at the 2015 national patient survey. The data showed that 73% of patients that completed the survey said that the last GP they saw or spoke to, was good at giving them enough time. Also, 65% said that the were good at involving them in decisions about their care and 70% said that the were good at explaining tests and treatments. Their satisfaction in these areas when they saw a nurse was slightly higher. All results were higher than the local Clinical Commissioning Group (CCG) average, which showed a commitment from clinicians to treat patients as partners in their care and treatment.

Clinical staff told us that patients at high risk of unplanned admissions to hospital, including elderly patients and those with complex needs, or in vulnerable circumstances, had a care plan in place to help avoid this. Patients care plans included their wishes, and decisions about resuscitation and end of life care. where appropriate.

Patient/carer support to cope emotionally with care and treatment

Several patients told us they received support and information to cope emotionally with their condition, care or treatment. They described the staff as caring and understanding. Where able, they were supported to manage their own care and health needs, and to maintain their independence.

The 2015 national patient survey information showed that patients were positive about the emotional support provided by the practice and rated it well in this area. Patients we spoke with and comment cards we received, were also consistent with the survey information. Patients told us they were supported to manage their own care and health needs, and to maintain their independence, where able.

Good

Are services caring?

Carers' details were included on the practice's computer system, to alert staff if a patient was also a carer to enable them to offer support. We noted that information was available to carers on the practice's website on how to access a number of support groups and organisations.

Staff we spoke with demonstrated that importance was given to supporting carers to care for their relatives, including those receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from a GP who knew them best, to determine whether they needed any practical or emotional support. We did not speak with any patients who had had bereavement to establish the level of support they received.

We noted that some information about bereavement services was available on the practice's website. One small poster was available in the reception and waiting area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice was responsive to their needs, as they were able to access care and treatment when they needed it.

The practice worked with other agencies to provide a range of services to meet patients' needs, and enable them to be treated locally.

The services were flexible, and were planned and delivered in a way that met the needs of the local population. For example, the practice had a higher percentage of patients with diabetes than the local average. The clinical staff worked with the local diabetes service. A specialist diabetic nurse held regular clinics at the practice and provided advice and support to patients to enable them to be treated locally.

There were plans to further develop the services but the practice was restricted from doing so, due to the limited capacity of clinical staff and consultation and treatment rooms. The GP partners assured us that they were actively looking to recruit another full-time GP and practice nurse. They had also obtained grant funding and approval to carry out alterations to the premises, to provide additional consultation and treatment rooms. A date for starting this work had yet to be agreed.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. Staff informed us they operated an open list culture, accepting patients who lived within their practice boundary.

The practice had a 20% white British population. The practice population included patients from various ethnic groups. Staff were able to describe a good awareness of culture and ethnicity issues. The practice had a large number of patients whose first language was not English. The staff were knowledgeable about language issues, and several staff including clinical and reception staff spoke appropriate languages, which enabled them to communicate directly with patients.

Staff also had access to local interpreters, where required. We noted that the practice's website had a translation facility to enable people whose first language was not English, to access the information about the services. However, we did not see any information in the waiting or reception area informing patients about access to this service. The practice manager agreed to review this.

Staff we spoke with said that they had completed recent equality and diversity training. They also said that equality and diversity issues were discussed at team meetings. The practice manager was updating the training matrix and files to show that all staff had attended the training.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

No patients expressed concerns about access to the premises. The practice was located on the ground floor of a health centre. There was limited space within the practice and the waiting area. We observed that the premises were largely accessible to people with restricted mobility and in a wheelchair, and mothers with prams or pushchairs.

The premises had been adapted to meet the needs of people with disabilities. However, we noted that certain facilities were not well set out to help people to maintain their independence and provide easy access. For example, the disabled toilet available to patients included baby changing facilities. The door did not open fully due to the position of the inner handle, and the height and location of the baby changing facilities, which created a potential risk of injury to patients in a wheelchair.

Staff were aware that advocacy services were available for patients who may require an advocate to support them. However, we did not see that patients had access to information about advocacy services on the practice website or at the surgery.

Access to the service

Patients we spoke with were satisfied with the appointment system as they were able to access the service when they needed to. They were usually able to make an urgent appointment or request a telephone consultation the same day. Three patients said that it could take five to ten days to get a non-urgent appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The 2015 national patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas compared to the CCG average. For example:

- 76% were satisfied with the practice's opening hours
- 87% were able to get an appointment to see or speak to someone the last time they tried
- 84% said the last appointment they got was convenient.
- 66% described their experience of making an appointment as good
- 56% said they usually waited 15 minutes or less after their appointment time to be seen
- 76% said they could get through easily to the surgery by phone

Patients were able to book an appointment in person, by telephone or on line. Non-urgent appointments could be pre-booked two weeks in advance**.** We found that the appointment system was flexible to meet the needs of patients. For example, several appointments were made available each day specifically for vulnerable patients or those at risk of admission to hospital.

Staff offered patients a choice of appointments to meet their needs, where possible. We saw that systems were in place to prioritise emergency and home visit appointments, or phone consultations for patients who worked or were not well enough to attend the practice. Staff added patients who needed to be reviewed urgently to the appointments to be seen that day, or arranged for a call back from a GP, where appropriate.

Where possible, telephone consultations and home visits were undertaken by a GP who knew the patient best.

Longer appointments were also available for people who needed them, including those with long-term conditions, a learning disability or experiencing poor mental health. Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. When closed, an answerphone message gave patients the telephone number they should ring depending on their circumstances.

We saw that the information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website. The practice manager told us that they regularly reviewed the appointment system and telephone response times, to ensure it met the demands on the service. We saw evidence of this. For example, a new telephone system had recently been installed to improve patient access.

The practice opening times were between 8.30am and 6.30 pm Monday, Tuesday, Wednesday and Friday, and from 8.30 am to 12.30pm on Thursday. The practice was contracted to provide extended opening hours. Extended appointment hours were offered until 7.45 pm on Monday which were particularly helpful for patients of working age.

The practice was restricted from offering further extended hours by the terms of the building lease agreement, in which the practice was located. Outside of the practice opening hour's patients could contact the out-of- hours service, which was provided by NEMS Community Benefit Services Limited.

There were two male and a female GP in the practice; therefore patients could choose to see a male or female doctor.

Listening and learning from concerns and complaints

Patients we spoke with said they felt listened to and were able to raise concerns about the practice. Not all patients were aware of the process to follow should they wish to make a complaint, but they said that they had not had cause to do so. We noted that limited information was available to patients to help them to understand the complaints procedure on the practice's website and at the surgery.

The practice's complaints procedure was generally in line with current guidance and contractual obligations for GPs in England. We noted the complaints procedure and information available to patients, did not state that patients could direct their complaint to NHS England rather than the practice, in addition to contacting the Parliamentary Health Service Ombudsman to investigate second stage complaints.

A system was in place for managing complaints and concerns. The practice manager was the nominated person for handling all complaints. Staff told us where possible; concerns were dealt with on an informal basis and promptly resolved.

The complaints log showed that the practice had received 16 complaints in the last 12 months. This recorded what each complaint related to, which helped the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

manager to consider any trends and patterns. There had been several complaints about appointment and prescription issues. The records showed that the practice had taken appropriate action to address the issues.

Records we looked at showed that complaints had been acknowledged, investigated and responded to in line with the practice's policy. The records indicated that appropriate learning and improvements had taken place.

Staff told us that the practice was open and transparent when things went wrong, and that patients received an apology when mistakes occurred. Complaint responses we reviewed indicated that patients had received an apology, where appropriate.

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 aims and objectives set out in the provider's statement of purpose were to provide patients with high quality personal care, and to seek continuous improvement of the practice. Staff we spoke with knew and understood the aims of the service, and what their responsibilities were in relation to these. They were clear that they placed patients' best interests at the centre of everything they did.

The vision and future plans for the practice had yet to be set out following recent changes to the partnership and senior managers.

The partners told us that in view of the changes, the practice was undergoing a settling period. The current focus was more on short to medium term plans for future development. Some initial key areas for development were set out. They planned to complete a clear business plan and establish regular meetings to review on-going improvements.

Governance arrangements

The practice had undergone considerable changes in the last 12 months. Senior managers demonstrated a commitment to improving the services. We found that the systems in place to drive improvements and monitor the quality and safety of services that people received were being strengthened.

Systems were in place for identifying, recording and managing risks. Various essential risk assessments had been completed; where risks were identified action plans had been implemented to minimise the risks.

The practice had a range of policies and procedures in place to govern the practice. These were available to staff electronically. A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and that these were shared with staff. Ten key policies we looked at had been reviewed recently. However, certain policies such as staff recruitment and infection control required adapted, as these did not detail all procedures followed at the practice.

Systems were in place to ensure that staff received essential information and were informed of changes. Records showed that various meetings took place to aid communication and the sharing of essential information. For example, monthly team and alternate monthly clinical meetings were held to share information and learning between the staff. All staff attended the team meetings, and the nurse and the GPs attended the clinical meetings.

The GPs and practice manager told us that they regularly reviewed the practice's business, finances, governance, performance and future plans. However, records were not kept to evidence this.

Leadership, openness and transparency

The leadership had been strengthened following recent changes to the GP partners and the practice manager. The staff team were starting to take on lead responsibilities to ensure that the service was well led, although this was in the early stages of development.

Staff we spoke with were clear about their roles and responsibilities, and felt that essential improvements were being made to ensure the practice was well managed. They also said that they felt valued, well supported, and involved in decisions about the practice.

Staff described the culture of the practice as open and supportive, and felt able to raise any issues with senior managers as they were approachable and listened. The practice manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place. Not all staff we spoke with were aware of this, but they had not had cause to use it.

Records showed that regular team meetings were held, which enabled staff to share information and to raise any issues.

Seeking and acting on feedback from patients, public and staff

A Patient Participation Group (PPG) had recently re-formed following the above changes. The PPG are a group of patients who work together with the practice staff, to represent the interests and views of patients so as to improve the service provided to them.

We spoke with two members of the PPG. They told us they felt supported in their role, to represent the views of patients to improve the service. The group had tried to enlist further members to represent all patient groups including younger people. However, no one had expressed an interest in joining at the point when we inspected.

Are services well-led?

Good

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

The practice obtained feedback from patients through surveys, complaints and complaints. However, in view of the changes to the partnership, patients had not been issued a recent satisfaction survey. The survey had recently been updated to include further questions. The practice manager informed us that this would be issued to patients by the end of December 2015, to establish if they were happy with the changes made to the services. The PPG would be involved in the process.

We were informed of various changes that had been made in response to feedback from patients. For example, a new telephone system had recently been installed to improve patient access. Also, appointments and repeat prescriptions were now available on-line.

The results of the family and friends test for the period January to April 2015 were displayed on the practice's website. The results showed that most people had recorded that they were extremely likely or likely, to recommend the practice to friends and family if they needed similar care or treatment.

Discussions with staff and records reviewed showed that the practice obtained feedback from staff through team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the quality of the services provided.

Management lead through learning and improvement

The commitment to learning and the development of staffs' skills was recognised as essential to ensuring high quality care. Staff told us that they were actively supported to acquire new skills and develop their knowledge to improve the services. For example, the practice nurse had undertaken relevant training to enable her to lead on the reviews of patients with long term conditions.

Records we looked at showed that staff received on-going training and development. In view of the recent changes to the partnership and senior managers, not all staff had received an annual appraisal to enable them to provide high standards of care. We were assured that a revised appraisal plan was in place for all staff to be appraised in 2015. This will outline their personal training and learning needs, from which action plans will be documented.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings to ensure lessons were learnt and improvements had taken place to minimise further occurrences. For example, a patient's essential blood test had been missed as this had not been appropriately recorded. The systems were strengthened following the incident to ensure the need for visits and blood tests are clearly recorded.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** Effective recruitment procedures were not followed to ensure the information specified in Schedule 3 was available in regards to all persons employed. Regulation 19 (2) & (3).