Bean Road Medical Practice

Quality Report

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

Ratings

Overall rating for this service	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 Bean Road Medical Practice on 7 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the care of older people, people with long term conditions, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing safe, effective, caring, responsive and well-led services for families, children and young people.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. There was a clear leadership structure and staff felt supported by management. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Summary of findings

- The practice frequently met with other organisations including district nurses, health visitors, social services, school nurses and midwives to discuss patients with complex needs and to ensure that they meet people's needs.
- The practice had a complaints policy which was in line with recognised guidance. The practice informed us that they had not received any written complaints within the last 12 months. We did not see evidence that the practice monitored themes from the verbal complaints they had and that learning was shared.
- We found that appraisals were overdue for the members of the reception team. The practice manager had recognised this prior to our inspection and had scheduled appraisals for these staff.

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

Importantly the provider must:

- Ensure that young people who attend the service without a parent or guardian are involved in an assessment of their needs by a person with the required level of skill for this particular task. In order for the most appropriate cause of action to be decided; assessments must take into account current legislation and consider relevant nationally recognised evidence based guidance.

In addition the provider should:

- Develop a proactive approach to identifying and targeting health promotion and preventative care services such as cervical screening, NHS health checks and a programme of flu vaccinations for patients who would benefit from them.
- Establish a system for monitoring themes and trends with regards to verbal complaints received by the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients were assessed and well managed. Lessons were learned and communicated widely to support improvement. there were enough staff to keep patients safe. The practice had systems to manage and review risks to vulnerable children, young people and adults.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the 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. The practice nurses provided appointments for a variety of health checks and conditions. These included blood tests, health checks, baby immunisations and health reviews for patients with long term conditions such as diabetes or respiratory problems.

Clinical staff demonstrated an understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). However, the practice advised that instead of booking appointments for young people who attended the practice alone (over the age of 16), staff would gather as much information from the person attending and discuss with the GP for them to determine if it was acceptable to see the patient alone. Reception staff also told us that they would not arrange an appointment for a patient under 16 years on their own without discussing with the practice manager or a GP first; instead of booking an appointment and then appropriately flagging it with the GP.

Staff worked with multidisciplinary teams. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the national patient survey published in January 2015 showed that 81% of the respondents described their overall experience of the practice as good. Patients said staff treated them with dignity and

Summary of findings

respect and were positive about the service experienced. Information for patients about the services available was easy to understand and accessible. The practice had a register of carers in place and the practice had recently implemented a carer's pack which included a carer's charter, carer's newsletter and information on how to access carer support groups. 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. We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The practice served a diverse population of all ages and various ethnic backgrounds. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice employed GPs who could speak additional languages in line with the needs of their patient's population.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

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. The practice informed us that they had not received any written complaints within the last 12 months but they had received verbal complaints which were resolved at first point by the practice manager.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. Staff we spoke with were all clear about their own roles and responsibilities. Staff told us how moral had improved over time, particularly since the lead GP joined and since the team had stable leadership with a new practice manager in post as well as a newly appointed practice nurse. Staff told us that they felt valued, well supported and knew who to go to in the practice with any concerns. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

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 them longer appointments as well as home visits.

Every patient over the age of 75 had a named GP who had been agreed in line with individual preference. The practice had made use of the gold standards framework for end of life care. The practice had a register of their patients who were receiving end of life care and treatment so that the team were aware of these patients and could respond promptly when needed.

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

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. Clinical staff demonstrated an understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). However, the practice advised that instead of booking appointments for young people who attended the practice alone (over the age of 16), staff would gather as much information from the person attending and discuss with the GP for them to determine if it was acceptable to see the patient alone. Reception staff also told us that they would not arrange an appointment for a patient under 16 years on their own without discussing with the practice manager or a GP first; instead of booking an appointment and then appropriately flagging it with the GP. There were systems in place to identify and follow up children living in disadvantaged

Summary of findings

circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. We saw good examples of joint working with midwives, health visitors and school nurses.

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.

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 kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as homeless patients and patients with a learning disability. Structured annual reviews were undertaken for patients with a learning disability. The practice nurse had recently completed updated training on caring for patients with learning disabilities. The nurse was in the process of planning annual reviews for five of the patients on the learning disabilities register and was also developing visual, user friendly health check guides in line with this. It offered longer appointments for people with a learning disability.

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). Performance for mental health related QOF indicators was above the national average. Care plans were in place for 100% of patients experiencing poor mental health compared to the national average of 86%. Face to face reviews had been completed on the all of the practice's patients experiencing poor mental health.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. 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.

Summary of findings

What people who use the service say

We spoke with four patients on the day of our inspection and we gathered further views of patients from the practice by looking at 31 completed Care Quality Commission (CQC) comment cards. Patients told us that all staff within the practice treated them with dignity and respect. Patients told us that they did not feel rushed during their appointments.

Patients described the environment as clean and safe. Patients wrote that their needs were responded and listened to and the staff were caring, helpful, friendly and approachable.

We received positive responses with regards to the GP and nurse care in the practice, particularly around the continuity of care. Patients said the staff were experienced, friendly and helpful, this also reflected comments seen on the CQC comment cards.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015. The data from the national patient survey showed that 81% of the respondents described their overall experience of the practice as good.

Areas for improvement

Action the service MUST take to improve

Ensure that young people who attend the service without a parent or guardian are involved in an assessment of their needs by a person with the required level of skill for this particular task. In order for the most appropriate cause of action to be decided; assessments must take into account current legislation and consider relevant nationally recognised evidence based guidance.

Action the service SHOULD take to improve

Develop a proactive approach to identifying and targeting health promotion and preventative care services such as cervical screening, NHS health checks and a programme of flu vaccinations for patients who would benefit from them.

Establish a system for monitoring themes and trends with regards to verbal complaints received by the practice.

Bean Road Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included GP specialist advisor and a practice manager specialist advisor.

Background to Bean Road Medical Practice

Bean Road Medical Practice is situated in the town of Dudley. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided included offering extended hours, avoiding unplanned admissions, phlebotomy (taking of blood samples) and minor surgical procedures such as joint injections.

There are approximately 2,060 patients of all ages registered and cared for at the practice. The practice building is purpose built with all treatment and practice office areas on one floor. The building has car parking, with allocated spaces and access for those with a disability.

The practice team consists of a two male GPs, one of which is the lead GP and the other is a long term locum GP employed by the practice. There are two female GPs who are also long term locums. A locum GP is a fully qualified doctor who can provide temporary cover to fill a vacancy or cover sick leave, staff holidays or training commitments. The practice also employs two practice nurses. The practice manager works collaboratively with the lead GP to take care of the day to day running of the practice and is supported by a team of four reception staff who cover reception, secretarial and administrative duties.

The practice is open from 8am to 6.30pm on Monday to Friday; with appointments available from 8:30am to 6pm. Patients can book appointment over the phone, online and in the practice. The practice does not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of the 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:

Detailed findings

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

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

We carried out an announced inspection on 7 July 2015 at the practice. During our inspection we spoke with two GP's, one nurse, two reception staff, a practice manager and four patients. We spoke with the three members of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We reviewed 31 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used information from a variety of sources to help them to identify and manage risk, learn from reported incidents and improve patient safety. These included national patient safety alerts, reported incidents and significant events.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings dating back to April 2006 where these were discussed. A practice meeting was held each month to review actions from past significant events and incidents. 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.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used an incident form which was available as a hard copy behind reception and also on the practice's electronic system. We saw how the completed forms were shared with the lead GP and the practice manager. The practice would monitor incident themes by keeping a significant event and incident file which was reviewed and discussed at each practice meeting.

We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, we saw how the practice had acted appropriately during a medical emergency. The incident was effectively managed at the time and also logged as a significant event. There was evidence that the practice had learned from incidents and significant events and that the findings were shared with relevant staff. A further example was when the practice faced problems in reviewing patient discharge summaries during the migration of their electronic system. The practice adjusted their review process so that the GPs always had additional paper copies to hand to ensure that the review process could continue during system downtime periods. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to the practice staff. The practice manager received alerts directly and had signed up to a central alerts cascade from the 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. The practice manager had developed an alerts file which was kept in reception, the file was populated with every alert and categorised for the GPs, nurses and non-clinical staff. The file contained a signature sheet where staff were required to sign and date to support that they had read the alerts. The practice manager would review this on a regular basis with each new alert or guidance update, to ensure staff were reading the updates.

Staff we spoke with were able to give examples of recent alerts that were shared with the practice and how they were acted on within the practice. For example, the practice carried out a review in line with guidance from the National Institute for Health and Care Excellence (NICE) and made adjustments to the dosage in the use of a particular type of steroid in patients with Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. They also told us alerts were discussed at the weekly practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. The National Institute for Health and Care Excellence (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.

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. The practice had a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. The lead safeguarding GP was aware of vulnerable children and adults and records. 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. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to contact the relevant agencies in working hours and out of normal hours.

The practice kept a comprehensive safeguarding folder which contained safeguarding policies, up to date contact and referral details, domestic abuse pathways and safeguarding protocols. The folder was accessible in electronic and paper formats so that staff could always access safeguarding information when needed. Staff told us that the safeguarding folder was bought to regular multi-disciplinary meetings which included regular attendance from district nurses, social workers, community nurses and health visitors. We saw evidence of the multi-disciplinary meetings to show that they took place every two months and that additional representatives from other organisations such as Mental Health and the Clinical Commissioning Group (CCG) also attended. Clinical Commissioning Group (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 could also see that the practice discussed children and young people known to be living in vulnerable circumstances, including those with child protection plans or in the care of the local authority as part of these meetings; as well as missed appointments and attendances at accident and emergency. There was a system to highlight vulnerable patients on the practice's electronic records. This included patients receiving end of life care as well as children who had a child protection plan in place. The practice shared a report with us to demonstrate that those with child protection plans in place were regularly reviewed and we saw that the report was also included in the multi-disciplinary meetings.

Staff were proactive in monitoring missed appointments and attendance at accident and emergency for children and vulnerable adults. These were listed by the practice nurses and the administration team and brought to the attention of the GPs on duty as well as the lead GP for safeguarding. The GPs and practice nurses would complete a daily check of any children or vulnerable adults who attended accident and emergency and the lead GP and the practice nurses would following up on missed appointments. A secondary check for patients who attended accident and emergency was also completed by the practice staff and an updated list of attendances was generated for discussion at the multi-disciplinary meetings to discuss any key themes and further actions. We saw evidence that these discussions took place within the multi-disciplinary meeting minutes.

There was a chaperone policy, which was visible on the waiting room noticeboard and on consulting room doors. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing and reception staff had been trained to be a chaperone. 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. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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. A log of the fridges' temperature ranges had been recorded twice daily. This demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range; the practice staff followed the policy.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework

and covered all required areas. We spoke with members of the administrative team who were able to explain how changes to patients' repeat medicines were managed and staff were able to demonstrate the system they used to flag up patients who required a medication review. Annual face to face medication reviews were in place for all patients who were registered at the practice. Medication reviews for patients with dementia had been undertaken for 85% of their patients for the year so far.

Staff confirmed that all new medication requests were managed by the GP and all prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had established a service for patients to pick up their dispensed prescriptions from the local pharmacy and the practice had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. Patients could order their repeat prescriptions in person, online or by telephone.

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

Cleanliness and infection control

We observed the premises to be 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.

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. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice nurse was the lead for infection control, they had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the lead had completed a recent infection control audit in June 2015 and the practice had developed an action plan outlining some improvements for action such as staff refresher training on infection control.

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.

We saw records that confirmed the practice had made arrangements for an accredited environmental organisation to complete a legionella risk assessment, the risk assessment was planned to be completed approximately one week after our inspection visit; we saw evidence of booking confirmations to support this. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A Legionella risk assessment is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place.

Equipment

Staff we spoke with confirmed that they had the equipment they needed for the care and treatment they provided. 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 which was January 2015. We saw evidence that the equipment used by staff was calibrated in June 2015, this included blood pressure measuring devices and spirometer devices. A spirometer measures lung function including the volume and speed of air that can be exhaled and inhaled.

Staffing and recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. Most of the team had been at the practice for a long time, with the newest permanent staff members joining in April and May 2015. The staff demonstrated a good understanding of the practices protocols and were knowledgeable with regards to the running of the practice, patient safety needs and their responsibilities within the practice.

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. Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all staff members. For example, qualifications and registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice manager had developed individual files for each staff member since joining the practice at the end of April 2015, these included personnel files for the long term locum GPs who worked at the practice on a regular basis. The practice employed three locum GPs to who worked regular weekly shifts at the practice. A locum GP is a fully qualified doctor who can provide temporary cover to fill a vacancy or cover sick leave, staff holidays or training commitments. We saw that appropriate recruitment checks were in place prior to providing locum cover at the practice.

Monitoring safety and responding to risk

Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice also had a health and safety policy and systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, health and safety risk assessments and fire risk assessments. We saw that the latest health and safety and fire risk assessment was completed in May 2015. Records showed that staff were up to date with fire training and the practice had an update scheduled in for July 2015. The practice completed regular fire drills; we saw that the last fire drill was completed in January 2015 and regular fire alarm tests were taking place.

The practice also kept a maintenance log to record any maintenance requirements throughout the practice for, any maintenance requirements would be managed through the lead GP.

The practice had systems for identifying patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia and learning disabilities. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable. Reception staff also had this information to help them prioritise potentially urgent cases. Staff were aware of how to report risks and who to report them to.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

The practice had completed a risk assessment to assess the risk of not having an automated external defibrillator (AED) on site; this is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. To control the risk, practice staff were trained in Cardiopulmonary resuscitation (CPR) and trained to immediately consult with the GP on duty in the event of a person going in to cardiac arrest. The practice acknowledged that the there is reasonable probability for the use of an AED on site and therefore decided to consult with the Clinical Commissioning Group (CCG) with regards to purchasing an AED.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac

Good

Are services safe?

arrest, anaphylaxis and hypoglycaemia. 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff we spoke with all demonstrated knowledge of National Institute for Health and Care Excellence (NICE) guidance and local guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They accessed guidelines from the NICE website and disseminated them to staff. We saw minutes of meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. The nurses also attended regular educational updates to ensure they were up to date with best practice guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. Feedback from patients confirmed they were referred to other services or hospital when required. The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

The lead GP specialised in various clinical areas including Sexual Health, Diabetes, Asthma, Substance misuse, COPD and Minor Surgery. The practice nurses supported this work to allow the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders such as Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. The practice had a register of patients with COPD and the practice shared a report with us to show that 83% of their patients with COPD had received an annual review in the last 12 months.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. 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 practice had a system in place for completing clinical audit cycles. The practice showed us examples of two clinical audits that had been undertaken in the last two years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit of patients on nonsteroidal anti-inflammatory drugs (NSAIDs) had been carried out. The aim of the audit was to identify all patients on this medication with specific conditions in line with NICE guidance. Where continued use of NSAIDs were required, the audit showed where the practice changed to other medicines in line with Medicines and Healthcare products Regulatory Agency (MHRA) and NICE guidelines. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (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 practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The practice achieved 91% of the total QOF target in 2014, compared to the local average of 95% and the national average of 94%. The practice was aware of the areas where performance was not in line with national or CCG figures and we discussed the practices plans setting out how these were being addressed, the plans included a review of the recall process and robust, opportunistic screening services to ensure no patients are missed. Specific examples to demonstrate this included:

Good

Are services effective?

(for example, treatment is effective)

- Performance for some of the diabetes related indicators was similar to the national average. However, areas such as flu jabs for patients with diabetes were lower than the national average, with 69% of patients with diabetes having flu jabs, compared to the national average of 93%.
- The percentage of cervical screening tests for women aged between 25 and 64 was 65%, compared to the national average of 81%. We spoke with the practice nurse who was aware of the figures and an up to date report was shared with us to show that the practice was improving in this area, with the percentage increasing to 71% at the point of our inspection. The practice nurse told us that the practice would be completing a cervical screening drive to focus on this area moving forward.

Performance for mental health related QOF indicators was above the national average of 86%, the practice had care plans in place for 100% of people experiencing poor mental health. Face to face reviews had been completed on the practice's patients experiencing poor mental health, the practice was in line with the national average; with a practice achievement of 83% for this area. The latest QOF data also shows that 95% of the practice's patients experiencing poor mental health had their smoking status recorded; this was also in line with the national average of 95%. Patients experiencing poor mental health were offered an annual health review which the practice booked as an extended appointment at a time convenient for the patient and with the GP they preferred to see.

Every patient over the age of 75 had a named GP who had been agreed with each of them based on their preference. The practice had made use of the gold standards framework for end of life care. The practice had a register of their patients who were receiving care and treatment at the end of life so that the team were aware of these patients and could respond promptly when needed. They provided information about those patients to the local out of hours and ambulance service. Patients at the end of life had written care plans and where appropriately agreed had 'do not attempt resuscitation information' available so that patients would not be resuscitated against their wishes.

The practice also kept a register of patients identified as being at high risk of an unplanned admission to hospital and of those in various vulnerable groups such as homeless patients and patients with a learning disability. Structured annual reviews were also undertaken for patients with a learning disability. The practice nurse had recently completed updated training on caring for patients with learning disabilities, the nurse was in the process of planning annual reviews for five of the patients on the learning disabilities register and was also developing visual, user friendly health check guides in line with this.

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 essential courses such as annual basic life support. The GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We looked at five staff files during our inspection and we found that appraisals were overdue for the members of the reception team, for instance, one member of staff had not had an appraisal for over 12 months. The practice manager had recognised this prior to our inspection and had scheduled appraisals for these staff.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example nurse training in cervical cytology and their extended roles in seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease. All the staff we spoke with felt supported by the practice and were encouraged to develop their knowledge and skills. The practice provided in house education sessions for staff as part of the weekly practice meetings and ensured staff had protected learning time to attend external training events and complete e-learning.

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 111 service both electronically and by post. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge

Good

Are services effective?

(for example, treatment is effective)

summaries and letters from outpatients were usually seen and actioned on the day of receipt. 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.

Emergency hospital admission rates for the practice were higher at 25% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a two weekly check of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed. The practice completed an audit of patients who had declined hospital admission in the last year and the lead GP followed up by contacting any patients who had declined admission.

Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. The practice held multidisciplinary team meetings every two months to discuss patients with complex needs. For example, those with end of life care needs and children on the at risk register. These meetings were regularly attended by district nurses and health visitors and also included other agencies including social services and midwives.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. 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.

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. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Staff kept up to date with legislation by attending regular updates facilitated by the Clinical Commissioning Group.

Patients 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. These care plans were reviewed annually and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Clinical staff demonstrated an understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). However, the practice advised that instead of booking appointments for young people who attended the practice alone (over the age of 16), staff would gather as much information from the person attending and discuss with the GP for them to determine if it was acceptable to see the patient alone. Reception staff also told us that they would not arrange an appointment for a patient under 16 years on their own without discussing with the practice manager or a GP first; instead of booking an appointment and then appropriately flagging it with the GP.

There was a practice policy for documenting consent 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 discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery was being followed.

Good

Are services effective?

(for example, treatment is effective)

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice nurses provided appointments for a variety of health checks and conditions. These included blood tests, health checks, childhood immunisations and health reviews for patients with long term conditions such as diabetes or respiratory problems. The practice also provided phlebotomy (taking blood samples) and spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). The practice had also recently started to offer smoking cessation support and advice for patients who wished to stop smoking. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice began offering NHS Health Checks to all its patients aged 40 to 75 years, from June 2015. Practice data showed that so far 1% of patients in this age group had taken up the offer of the health check. We were shown the process for following up patients within one week if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice's performance for the cervical screening programme had started to improve, with a performance of 71% at the point of our inspection. This was lower than the national average of 81% however the practice had started to implement methods to improve this area which included adding alerts to the patient's record for those who did not attend for their cervical screening test in order for the lead GP and the practice nurse to follow up. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening and planned on completing a practice drive on cervical screening moving forward so that the practice could focus on this area.

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 was below average for the majority of immunisations where comparative data was available. For example:

- National data showed that the practice was lower than the national average figures for providing flu vaccinations to patients aged 65 or over (32% compared with 52%) and for those in high risk groups (59% compared to 73%).
- Childhood immunisation rates for the vaccinations given to under twos ranged from 85% to 90% and five year olds from 82% to 96%. Most of the rates for vaccinations given to under twos were below the CCG averages which ranged from 86% to 100%.

The practice had started to address the low vaccination rates by employing a new full time nurse and by offering early morning clinics and evening appointments to suit the working population. The newly appointed practice nurse had developed patient health questionnaires and a travel risk assessment form for receptionists to distribute to patients in order to collate more information regarding the practices population needs. The nurse was in the process of collating the questionnaires and planned to analyse the data to ensure opportunities were not being missed with regards to health promotion and lifestyle clinics. The nurse also told us how she planned on using the data as part of the recalling system to ensure that reviews, vaccinations and health checks were continually offered to patients in line with their needs.

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 published in January 2015. The data from the national patient survey showed that 81% of the respondents described their overall experience of the practice as good compared to the CCG average of 84% and the national average of 85%. Further results showed a mixture of high and low percentages compared with CCG and national averages. For example:

- 92% said the GP was good at listening to them. This was higher than the CCG average of 88% and national average of 89% however, 85% said the last nurse they saw was good at listening to them and this was lower than the CCG average of 92% and below the national average of 91%.
- 91% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%. Seventy nine percent said the nurses gave them enough time; this was also higher than the CCG average of 93% and above the national average of 92%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%. Ninety five percent said they had confidence and trust in the last nurse they saw or spoke to, this was lower than the CCG and national averages of 97%.

We spoke with four patients during our inspection. Patients said staff treated them with dignity and respect and were positive about the service experienced. These comments were also reflected in the CQC comment cards patients completed to tell us what they thought about the practice. We received 31 completed cards and most of them contained positive feedback about the practice. The comments gave feedback on how the practice was caring and how the staff took time to explain things and listen well. Patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Respondents to the national patient's survey rated the helpfulness of the receptionists as 80%; this was below the CCG and national averages of 87%. We discussed the survey results with the practice during our inspection; we found that the data reflected a period of change for the practice, during a time when some long term staff members had retired. Comments from patients during the inspection were positive with regards to the care of GPs, nurses and helpfulness of reception staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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 which helped keep patient information private. Staff told us that patients were given the option to speak with them in a private area away from the reception desk if they needed to talk in 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. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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

Care planning and involvement in decisions about care and treatment

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. We spoke with three

Good

Are services caring?

members of the newly developed patient participation group (PPG) during our inspection. A PPG is a group of patients registered with a practice who work with the practiceto improve services and the quality of care. The PPG members told us how there was good continuity of care at the practice and how the patients had built good long term relationships with the GPs and nurses.

We also reviewed the national patient survey responses to questions about GP and nurse involvement in planning and making decisions about their care and treatment.

We also reviewed the national patient survey responses to questions about GP and nurse involvement in planning and making decisions about their care and treatment.

- 75% said the last GP they saw was good at explaining tests. This was below the CCG and national averages of 86%. Eighty seven percent said the last nurse they saw or spoke to was good at explaining tests and treatments. This was below the CCG average of 91% and lower than the national average of 90%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%. Eighty one percent said the last nurse they saw or spoke to was good at involving them in decisions about their care. This was lower than the CCG average of 87% and national average of 85%.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. The patient survey information we reviewed showed that the survey responses were less positive about the emotional support provided by the practice. For example:

- 83% said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national averages of 85%.
- 82% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 90%.

The practice's computer system alerted GPs if a patient was also a carer, the practice had a register of carers in place and the practice had recently implemented a carer's pack which included a carer's charter, carer's newsletter and information on how to access carer support groups. Further information could also be accessed on the practice website and a carer's corner was also situated in the reception area at the practice. Both the website and the carer's corner held a variety of information on carer's workshops and local carer's hubs. 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.

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 by giving them advice on how to find a support service, the practice would also give bereavement leaflets for people to take away. The practice would also give the patients the option to be referred for counselling to provide further support to them. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 patient's needs and had systems in place to maintain the level of service provided. The practice served a diverse population of all ages and various ethnic backgrounds. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The lead GP told us how the practice had employed long term locum GPs who could speak additional languages in line with the needs of their practice population. One patient we spoke with on the day of our inspection told us that this worked well and helped with communication barriers for those who did not have English as a first language.

We saw minutes of meetings of multi-disciplinary meetings to support that the practice regularly engaged with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from suggestions provided by patients. For example, the practice decided to open their appointments up on a Wednesday afternoon instead of closing for half day. This was based on feedback they had received from patients who requested further access to appointments during afternoons.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The practice was culturally sensitive and offered an interpreting service for patients who didn't have English as a first language and the GPs spoke a number of languages including Urdu, Punjabi and Hindi. Healthcare promotion leaflets and information was also available in a variety of languages both on the practice website and within the practice. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

Access to the service

The surgery was open from 8am to 6.30pm on Monday to Friday, with appointments available from 8:30am to 6pm. Comprehensive information was available to patients about appointments on the practice website and within the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments online. 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 on the practice website, in the practice leaflet and also on notices within the practice.

The patient survey information we reviewed showed mixed responses to questions about access to appointments. For example:

- 72% were satisfied with the practice's opening hours compared to the CCG and national averages of 75%.
- 65% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 89% said they could get through easily to the surgery by phone compared to the CCG average of 68% and national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 32% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63% and national average of 65%.

We found that the survey responses regarding access and appointments reflected the few negative comments received on the CQC comment cards. Three of the 31 comment cards stated that sometimes patients need to wait long in reception for their appointments. Staff told us that they endeavour to keep patients informed of delays if clinics are running late.

The practice was higher than the CCG and national averages for convenience of appointments. Ninety seven percent of the survey respondents said the last appointment they got was convenient. This was higher than the CCG and national averages of 92%.

Patients we spoke with were also satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent and it was often a GP of their choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients showed that those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice offered longer appointments for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made by a named GP.

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 were unable to review complaint records as the practice informed us that they had received no written complaints within the last 12 months. Staff told us that complaints had been made verbally and that these were resolved at first point by the practice manager. The practice did not have a system for logging their verbal complaints and therefore we could not see evidence that the themes from their verbal complaints were monitored and actions taken where appropriate. The practice could not demonstrate where lessons were learnt in relation to the verbal complaints they had received.

We saw that information was available to help patients understand the complaints system. 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.

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 to put the patients' needs at the heart of everything they do. We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff within a hard copy policy folder and on each computer within the practice. We looked at four of these policies and procedures and most staff had signed and dated a cover sheet to confirm that they had read the policy. All of the policies we looked at had been reviewed and were up to date. The practice manager was responsible for human resource policies and procedures. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

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 the lead GP was the lead for safeguarding. Staff we spoke with were all clear about their own roles and responsibilities. Staff told us how moral had improved over time, particularly since the lead GP joined and since the team had stable leadership with a new practice manager in post as well as a newly appointed practice nurse. Staff told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Leadership, openness and transparency

Administrative staff told us that the clinical team and the practice manager were always approachable and would take the time to listen to all members of staff. Staff were involved in discussions about how to run and develop the practice. Staff were encouraged to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held at least once a month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff told us how they had recently implemented a uniform policy where reception staff were given professional uniforms to wear as well as name badges. Reception staff told us that this worked well and made them feel valued, as a professional part of the practice.

Seeking and acting on feedback from patients, public and staff

The practice valued feedback from patients and had recently developed a patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG had met twice since forming as a group in May 2015; the group included male and female representatives of different ages and from various population groups. We spoke with three members of the PPG and they were very positive about the role they played and told us they already felt engaged with the practice. The PPG shared their plans of holding a PPG meeting every two months; we saw an action plan from the meeting held in June 2015 where the PPG were exploring the options of guest speakers, such as a dietician for diabetic care.

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.

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 appraisals for clinic staff had taken place and that appraisals for non-clinical staff were in progress. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers

Are services well-led?

Good

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

attended. An example was where staff had attended a Prevent Workshop in May 2015 which was facilitated through the CCG (Clinical Commissioning Group). The aim of the training was to educate staff and raise awareness in recognising the signs of vulnerability to radicalisation and how to follow the correct reporting procedures. 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The practice advised that instead of booking appointments for young people who attended the practice alone (over the age of 16), staff would gather as much information from the person attending and discuss with the GP for them to determine if it was acceptable to see the patient alone. Reception staff also told us that they would not arrange an appointment for a patient under 16 years on their own without discussing with the practice manager or a GP first; instead of booking an appointment and then appropriately flagging it with the GP. Regulation 9 (1) The care and treatment of service users must - 1. be appropriate, 2. meet their needs, and 3. reflect their preferences Regulation 9 (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – 1. carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. 2. designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met. A. enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.