Dr Shirley Tinnion and Partners

Quality Report

Dr Shirley Tinnion & partners
Jackson Road
Aylesbury
Buckinghamshire
HP19 9EX
Tel: 01296 425775
Website: www.meadowcroftsurgery.co.uk

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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?	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 Dr Shirley Tinnion & Partners (also known locally as Meadowcroft surgery), Jackson Road, Aylesbury, Buckinghamshire, HP19 9EX on 30 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to require improvement for provision of safe service. It was good for providing effective, responsive, caring and well led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. The majority of information about safety was recorded, monitored and reviewed, appropriately. When issues were identified they were addressed with the exception of child protection safeguarding alerts and safety and security of prescriptions.
- Risks to patients were assessed and well managed in some areas, with the exception of those relating to infection control. For example, the practice had not carried out follow up infection control audit or risk assessment and some actions were still outstanding from previous audit.
- Data showed patient outcomes were 78% on average for all long term condition medicine reviews. However, we saw the practice had implemented a care planning project for patients with diabetes and the practice was expecting improved outcomes for diabetes patients in the future. The practice was in the process of rolling out similar care planning projects for other patients with long term conditions to improve the outcomes.
- We found that completed clinical audits cycles were driving positive impact on patients outcomes.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait for non-urgent appointments with a named GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs. However, the waiting area was congested and there was no low level desk at the front reception. This made communication with reception staff difficult for patients in wheelchairs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvements are:

- Ensure safeguarding training is undertaken for all clinical staff.
- Ensure the process for the handling of blank prescription forms are handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times.
- Ensure the practice assesses the risk of, and takes steps to prevent, detect and control the spread of infections, including taking action to resolve identified actions without delay.

In addition the provider should:

- Ensure regular medicine reviews are undertaken for patients with long term condition.

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 as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. The practice had started to address areas highlighted by a infection control audit carried out by external nurse, however follow up audit or risk assessments were not carried out and some action was still outstanding from the first audit. The practice was also required to develop schedules for changing disposable curtains and the cleaning of carpets and blinds. Prescriptions were not always stored, tracked and monitored safely. Medicines were handled safely and fridge temperatures were checked daily. There was a lead for safeguarding adults and child protection. There was a system to highlight vulnerable patients on the patient electronic record. However, we found one family record where only one of the three children at risk were highlighted.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patients outcomes were low for NHS health checks and cervical screening compared to the national average. We found that staff had basic understanding of the principles of the Mental Capacity Act 2005. However, they had not received any relevant training and there was no protocol in place. We found that 78% of patients had received a long term condition medicine reviews. However, we witnessed a care planning project had been undertaken for diabetes patients and the practice was expecting improved outcomes for diabetic patients in future data analysis. For example, the practice was involved in at diabetic care planning project with the Clinical Commissioning Group (CCG) and one of the GP was acting as a diabetic lead for the CCG. The practice was in the process of rolling out similar projects to improve the outcomes for patients with dementia and other long term conditions. This included assessing capacity and promoting good health. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Most of the staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these

Summary of findings

needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. There was evidence of completed clinical audit cycles and audits which were driving improvement in patients outcomes.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. The Asian link worker employed by the practice was playing a vital role in the community.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. For example, we noticed staff notice board was used for valuable suggestions and feedback. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, the practice had recruited a nurse to work with patients aged over 75 to reduce emergency and hospital admissions. We reviewed evidence that showed the practice had reduced emergency admissions. The practice was responsive to the needs of older people and offered rapid access, longer appointments and home visits for those with enhanced needs. Patients aged over 75 had a named GP to promote continuity of care. Flu vaccination rates for over 65 were above the national average. The premises were accessible to those with limited mobility with automatic main doors and disabled toilets. There was a register to manage end of life care and unplanned admissions. There were good working relationships with external services such as district nurses.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were clinical leads for chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. However, not all these patients had a named GP and data showed improvement was required in patients outcomes for long term conditions. However, the practice was working to improve these area and we had witnessed effective diabetic care planning which resulted improvements in diabetic patients outcomes. There was a secondary care diabetic nurse working one day a week in the practice. The practice nurse was sending blood test results to the diabetic patient before the patient attended their annual review. The practice had recruited a full time pharmacist to take on lead role in rolling out similar care planning projects for other long term conditions.

Families, children and young people

Good

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

Summary of findings

were aware of the legal requirements of gaining consent for treatment for those under 16. A separate facility was provided on the practice website for requesting online repeat prescriptions for under 16. Chlamydia testing kits were available in accessible location for under 25s. Appointments were available outside of school hours and the premises were suitable for children and babies. Antenatal appointments and postnatal clinics were available. We saw good examples of joint working with midwives, health visitors and school nurses. The Asian link worker was employed to assist diverse multi-ethnic community.

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. Extended hours appointments were available on minimum three or maximum five mornings and one evening during weekdays until 7:30pm. The practice was proactive in offering online services. Health promotion advice was offered and smoking cessation advisor was recruited for one day a week. However, there was a low uptake for NHS health checks which was not reflecting the needs for this age group. For example, only 2% patients attended NHS health checks aged 40 to 75 years old. Extra flu clinics were offered on some Saturdays during flu season.

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 homeless people, travellers and those with a learning disability. It had not carried out the enhanced service to provide annual health checks for people with a learning disabilities. Data showed only 16 patients out of 32 patients on the learning disability register had received an annual health check and only 15 patients had completed care plans. However, the practice had developed a user friendly questionnaire for learning disabilities patients and GP was visiting care homes as and when required. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Most staff knew how to recognise signs of abuse in vulnerable adults and children. Most staff were aware of their

Summary of findings

responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. A translation service was available for patients who did not speak English.

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). Seventy eight per cent of people experiencing poor mental health had received care plan in last 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

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. Staff had received training on how to care for people with mental health needs and dementia. However, mental capacity act training had not been completed.

Summary of findings

What people who use the service say

The results of the national patient survey carried out in 2015 showed that patients were very positive about the services they received from Dr Shirley Tinnion & Partners. The survey had been completed by 107 patients. The GPs and management at the practice were committed to taking action to improve patient perception of the service.

The national survey showed that patients gave a positive rating about the care they received. The practice satisfaction scores on consultations showed 95% of practice respondents said GPs were good at listening to them and 90% of nurses were good at listening to them. The survey also showed 96% said the last GP they saw and 92% said the last nurse they saw was good at giving them enough time. These results were above the clinical commissioning group average.

The practice received positive feedback regarding how patients had confidence and trust in the last GPs and nurses they saw or spoke to. Data from national survey showed 89% of patients would recommend the surgery to others and this was above the clinical commissioning group average of 80%.

The practice patient participation group (PPG) had also completed a survey in 2014. Sixty seven patients responded to the survey. The responses identified some areas where the practice could improve. We saw the PPG and practice had developed an action plan to address areas for improvement. For example, the practice had reviewed the appointment system, to address the dissatisfaction of patients when booking the appointments. The practice had also taken the action in response to disability survey. For example, the practice had improved the facilities for disabled patients by introducing automatic main doors and disabled toilet near the waiting area.

During our inspection we spoke with 13 patients and two PPG members but there was no CQC comment card completed. Patients we spoke with were very positive about the care and treatment offered by the GPs and nurses at the practice, which met their needs. They said staff treated them with dignity and their privacy was respected. They also said they always had enough time to discuss their medical concerns. We received some comments relating to difficulties in obtaining appointments quickly with named GP.

Areas for improvement

Action the service MUST take to improve

- Ensure safeguarding training is undertaken for all clinical staff.
- Ensure the process for the handling of blank prescription forms are handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times.
- Ensure the practice assesses the risk of, and takes steps to prevent, detect and control the spread of infections, including taking action to resolve identified actions without delay.

Action the service SHOULD take to improve

- Ensure regular medicine reviews are undertaken for patients with long term condition.

Outstanding practice

The Asian link worker was employed by the practice for five hours per week to assist diverse multi-ethnic community. The patients were asking for Asian link worker services during consultations and worker was also acting as an interpreter during consultations. The Asian link worker was carrying out home visits, guiding patients for psychological support and referring to health visitors. The Asian link worker was playing a significant role in engaging with the community and was also promoting

awareness about diabetes and other long term conditions, screening programmes, dieting, obesity and domestic abuse. The Asian link worker was also attending liaison meetings at the practice.

Dr Shirley Tinnion and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a CQC inspection manager, a GP, a practice nurse, a practice manager and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr Shirley Tinnion and Partners

Meadowcroft Surgery is a purpose built premises with car parking for patients and staff. There was easy access for patients/carers with a ramp and automatic main door. All patient services are on the ground floor. The practice comprises of 11 consulting rooms, three treatment rooms, one patient waiting area and administrative and management office and meeting spaces.

There are six GP partners at the practice, two salaried GPs and two trainee doctors. Three GPs are male and seven female. The practice clinical nurse manager is supported by five practice nurses, two health care assistants and a phlebotomist (a specialist clinical worker who take blood samples from patients). The practice informed us they had recruited a new pharmacist taking a lead role in medicine reviews and health checks. The practice manager had been appointed in December 2013 and was currently working their notice. The practice manager is supported by operations manager, reception admin team leader and a team of administrative and reception staff. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

The practice has a patient population of approximately 14,021 including 11% with Asian ethnic background. The practice population of patients aged between 25 and 34 and 0 and 14 years are slightly higher than average and there are a lower number of patients over 60 years old.

The local community has areas of deprivation and the staff were aware of the needs of this section of the population. The appointment system allowed advanced appointments to be booked from two days to six weeks in advance. Urgent appointment slots were also available.

Services are provided from:

Dr Shirley Tinnion & partners (also locally known as Meadowcroft surgery)

Jackson Road

Aylesbury

Buckinghamshire

HP19 9EX

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the patient website. Out of hours services are provided during protected learning time by Bucks Urgent Care or after 6:30pm, weekends and bank holidays by calling NHS 111.

Detailed findings

We carried out an announced comprehensive inspection of the practice on 30 July 2015. We visited Dr Shirley Tinnion & Partners surgery during this inspection.

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 this service on 30 July 2015 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This practice had not been inspected before and that was why we included them.

How we carried out this inspection

Prior to the inspection we contacted the Aylesbury Vale Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Dr Shirley Tinnion & Partners. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 30 July 2015. We spoke with 13 patients and 15 staff. Comment cards had been available for patients to complete prior to our inspection but there was no completed cards received.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. A whistleblowing policy and safeguarding information was available for staff.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 18 significant events and incidents that had occurred during the last year and saw this system had been followed appropriately. Significant events meeting was held every three months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. This included receptionists, administrators and nursing staff, who knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used written statements and incident forms on the practice intranet and sent completed forms to the operations manager. They showed us the system used to manage and monitor incidents. We saw evidence of action taken as a result of one of the recorded incidents and that the learning had been shared. For example, when salaried GP raised concerns that seven and half minutes fast track appointment duration was not enough for treating patients with complex needs, the practice raised this as a significant event, reviewed the policy and decided to move back fast track appointment consultation time to 10 minutes. 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 emails and notices displayed in communal area to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were also discussed during team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most of the staff had received relevant role specific training on safeguarding with the exception of a few clinical staff. We found two GPs were in the process of completing adult safeguarding training and two nurses were in the process of completing level two in child safeguarding. In addition, we found one GP did not have a level three in child safeguarding, one nurse did not have a level two in child safeguarding, one GP and nurse child and adult safeguarding trainings details were not provided. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads 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. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. However, we found one family record where an alert had been placed on some of the family members but not all the children. This was despite

case conference minutes filed in the patient records. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and treatment rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Not all staff undertaking chaperone duties had carried out a Disclosure and Barring Service (DBS) check. However, we had found evidence of a risk assessment for the staff carrying out these duties who had not completed a DBS check. (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). The risk assessment determined that non-clinical staff, undertaking chaperone duties, were never left alone with patients and therefore a check was considered not to be required.

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were not handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as disease modifying medicines, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. For example, an audit identified that blood tests were not done for 19% of patients prescribed a disease modifying medicine used for the treatment of cancer and rheumatoid arthritis. The practice had taken steps to identify the patients and developed a protocol to improve in this area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by an authorised prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

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. For example, GPs were advised to take extra care when prescribing a specific anti biotic medicine to patients with the history of anaphylaxis (severe potentially life-threatening allergic reaction).

Cleanliness and infection control

We observed the premises to be clean and tidy with the exception of some dust found in one clinical treatment room and there was no date on disposable curtains in one room. 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. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For

example, nurse was observed using gloves while dealing with urine sample. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of such an injury.

The practice had a lead for infection control who also provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the CCG lead nurse had carried out an audit in November 2014 and the practice developed an action plan in January 2015 and some improvements identified for action were completed. However, some actions had not been completed and the practice had not carried out any follow up audit or infection control risk assessment. Minutes of practice meetings showed that the findings of the audit were discussed.

We found the bin containing clinical waste awaiting collection was locked but not secured properly and general waste bin was also overflowing.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was May 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers (an instrument for measuring the air capacity of the lungs), blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

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 in most cases. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

The practice had advertised one vacant post for full time nurse on their website. The practice was also planning to advertise for a new GP partner because one of the partners was leaving in near future. The practice had already recruited new practice manager who was due to start from September 2015 while current practice manager was leaving in mid- August 2015.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. The health and safety policy was supported by a range of risk assessments. For example, fire risk assessment and equipment safety.

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. Information on emergencies and health and safety was also detailed in the locum pack available in clinical room.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in June 2015.

The practice had carried out a fire risk assessment in October 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Nursing guidelines and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We discussed with the GP and nurses how NICE guidance was received into the practice. They told us this was identified through various sources including alerts, from the NICE website and from regional events. Staff we spoke with all demonstrated a good level of understanding and knowledge. We saw that templates used for patient care reflected NICE guidance.

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. Staff we spoke with informed us that patients were being referred to other services as and when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs and staff we spoke with told us support from colleagues was always available and readily given.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly during MAG (multi-agency group) meetings 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.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information 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 also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups (for example the homeless, patients with learning disabilities and patients with mental health problems). Annual medicine reviews were also undertaken for people with long term conditions (For example, diabetes, asthma, chronic obstructive pulmonary disease, chronic heart disease and dementia). We were shown data that on average 78% of these reviews had been carried out in the last year. The practice was aware of this and we saw the practice had implemented a care planning project for patients with diabetes and the practice was expecting improved outcomes. The similar care planning projects for patients with other long term conditions were in development and the practice was expecting new pharmacist to take a lead role in medicine reviews, medicine management, health checks and care planning to improve the outcomes.

We saw records of 14 audits and evidenced that these were driving improvement in performance to improve patient outcomes. For example, repeated audits of pre-diabetes where the practice was able to demonstrate the changes resulting since the initial audit. The practice had started diabetes care planning in 2014 and we had witnessed the increased diagnosis rate of diabetes from 3.7% to 4.9% during previous year. Initially this project was supported by Diabetes UK but it had been adopted and supported by the CCG. One of the salaried GPs was diabetic lead for CCG and was planning to rollout this project to other practices within the CCG.

Good

Are services effective?

(for example, treatment is effective)

All audits were filed on the shared drive accessible to practice staff and there was evidence of them being discussed at practice meetings. Clinical audits were used to monitor quality and systems to identify where action should be taken. 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). For example, following an alert from the Medicines Management Forums meeting regarding a medicine used to prevent inflammation and pain in the joints, muscles and tissues a clinical audit was carried out. The aim of the audit was to ensure all patients prescribed this medicine had blood test carried out in the last three months to monitor serious side effects. The first audit demonstrated that 19% patients were taking this medicine without appropriate monitoring compared to local CCG average of 22%. The practice developed relevant protocols and shared this information with all clinicians and medicine reviews and blood tests were brought forward. We saw evidence that the practice had planned follow up audit after four months to monitor the outcomes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice achieved 89% of the total QOF target in year 2013-14 as compared to national average of 94% but these figures were increased to 95% in year 2014-15. The practice was required to improve patient outcomes for diabetes, chronic kidney disease and chronic obstructive pulmonary disease (COPD). The practice was aware of all the areas where it was required to improve performance in 2015-16 and we saw action plans setting out how these were being addressed. For example, we saw improvements in diabetes outcomes since a care planning project was launched in 2014. The practice informed us they were expecting positive impact on patients outcomes with diabetes in future QOF results. We noted that practice nurse was sending blood test results asking diabetic patients to highlight their priorities before next appointment. The practice was in the process of rolling out similar care planning projects for other patients with long term conditions as well.

The practice's prescribing rates were similar to 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. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, discussed the rationale for changing medicines with the patient before making any changes.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had nine patients on the end of life register.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, we witnessed the practice was performing in line with CCG average for prescribing antibacterial medicine.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support and fire safety. However, not all staff had attended appropriate level of safeguarding training. We noted all GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was

proactive in providing training and funding for relevant courses, for example we reviewed records for online and face to face training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. Those with extended roles (for example, seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days 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 14% 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 and follow-ups were documented and that no follow-ups were missed. For example, we witnessed a record where patient was visited following day after discharge from the hospital, then care plan reviewed after four days and appropriate referral was sent to community services.

The practice held multidisciplinary team meetings every month to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register). These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. The practice informed us that care plans were in place for patients with complex needs and care plans were shared with other relevant services.

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 but there was no protocol in place and staff had not

Good

Are services effective?

(for example, treatment is effective)

attended any formal training in this area. All the GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

During our discussions staff gave examples of how a patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear 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).

There was a practice protocol and consent form 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.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS health checks to patients aged 40 to 75 years where potential health concerns were identified. The practice data showed that only two per cent of patients in this age group took up the offer of the health check which was below the national average. The practice was aware of these low figures. There were reasons such as 11% increase in patients list size during the last four years, two experienced practice nurses left the practice and four partners retired in last few months which impacted these outcomes. The practice had recruited two new nurses and a pharmacist. The practice was expecting pharmacist taking a lead role in health checks and improve the patients outcome.

The practice was offering smoking cessation advice and data showed 39% smokers stopped smoking in the last year. The practice's performance for the cervical screening programme was 76%, which was below to the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. The practice's performance for the bowel and breast screening programme was 49% and 73% respectively.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example: Flu vaccination rates for the over 65s were 75%, and at risk groups 51%. These were similar to national averages of 73% and 52% respectively.

Childhood immunisation rates for the vaccinations given to under ones were 99% which was above CCG average of 97%, under twos were 98% which was above CCG average of 96% and five year olds were 95% which was similar to CCG average of 95%.

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 conducted in 2015. This data showed 107 patients had completed the survey which was 33% of those who had been sent the questionnaire. We also reviewed the feedback and recommendations by the practice's patient participation group (PPG) and the results from the friends and family recommendation survey carried out by the practice (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 evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example the practice was rated highly for satisfaction scores on consultations with doctors and nurses with 95% of practice respondents reporting the GP was good at listening to them compared to the CCG average of 91% and national average of 89%. Ninety eight per cent said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.

We spoke with 13 patients and two PPG members on the day of our inspection and majority of patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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

The practice had confidentiality corner at the side of reception which was helping to maintain confidentiality. Additionally, 95% said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' or staff privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us he 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. For example, a patient was removed from the practice register due to extremely abusive behaviour towards the practice staff. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 94% of practice respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%. Ninety four per cent of practice respondents 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 81%.

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

Good

Are services caring?

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.

Staff told us that translation services were available for patients who did not have English as a first language. We also spoke with the Asian link worker who was employed by the practice for five hours per week. The Asian link worker was playing a vital role in the community by creating awareness about diabetes, screening programmes, dieting, obesity and domestic abuse. The patients were requesting for Asian link worker services during consultations because worker was acting as an interpreter and also supporting patients to explain and understand their health care needs.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, data from the national patient survey showed 97% of practice respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%. Ninety per cent of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.

The patients we spoke with on the day of our inspection were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The staff we spoke with demonstrated awareness of the support needs of carers. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 demands of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Many services were provided from the practice including diabetic clinics, mother and baby clinics, smoking cessation and citizen advice clinic. Citizen advice clinic was providing outreach services with regular sessions at the practice to give advice on benefits. The practice worked closely with health visitors to ensure that patients with babies and young families had good access to care and support.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, appointments system and surgery opening hours were reviewed as per recommendations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, nurses had thorough understanding of patients cultural and ethnic beliefs. Nurses informed us that insulin dosages were adjusted for diabetic patients who were fasting for religious reasons. The practice nurse informed us that along with community diabetic nurse they had organised an education session in the local mosque with the involvement of community leaders.

Patients living in the local care home were registered with the practice. We found only 16 patients out of 32 patients on the learning disability register had received an annual health check and only 15 patients had completed care plans. However, the practice had developed a user friendly questionnaire for learning disabilities patients and GPs and nurses supported these patients by offering visits as and when the patients required. For example, the practice nurses were organising quarterly diabetic clinics at the nursing home and were also educating nursing home staff. The practice recognised the needs of carers and ensured they received advice and support appropriate to their needs.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if needed. 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. We saw small waiting area which was congested and there was limited space for wheelchair, prams and mobility scooters. GP informed us that planning permission was under consideration for extending or reconstructing the new building. There were automatic main doors and the practice corridors enabled access for patients who used wheelchairs and mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

A hearing induction loop system was available to assist patients using hearing aids and written information could be enlarged for patients with a visual impairment. A low level desk area was not available at the reception which was making it difficult for wheelchair and mobility scooter users.

Staff told us that they had registered patients who were of "no fixed abode" 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.

Staff we spoke with had good understanding of equality and diversity. The practice had a policy and it was discussed during team meetings but they had not attended the formal training in this area.

Access to the service

The surgery was open from 8am to 6:30pm Monday to Friday. The surgery was closed on bank and public holidays and it was advised to call 111 for assistance during this time. The surgery offered range of scheduled appointments to patients every weekday from 8am to 5:40pm including open access appointments with a duty GP throughout the

Good

Are services responsive to people's needs?

(for example, to feedback?)

day. The surgery opened for extended hours appointments minimum three or maximum five early mornings from 7am to 8am and one late evening from 6:30pm to 7:30pm. The surgery also offered seasonal flu clinics on some Saturday mornings during flu season.

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

Longer appointments were also available for older patients, those experiencing poor mental health, leg ulcer management, health checks for patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Patients who could not attend the practice were also offered home visits when needed.

The GP national patient survey 2015 information we reviewed showed patients responded positively to questions about access to appointments. For example, 91% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%. Eighty five per cent were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%. Eighty four per cent said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average of 73%. Ninety five per cent said they found receptionists at this surgery helpful as compared to CCG average of 87%. Fifty eight per cent said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

Patients we spoke with were 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 although this might not be their GP of choice. Feedback from staff reported that routine appointments with a named GP were available two to six weeks in advance or a named GP usually returned the phone call within a week. A range of appointments were offered including routine, two to six weeks and two days in advance and on the day urgent appointments. Telephone consultations were also available which were useful for patients who worked or those that found it difficult to attend the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The complaints procedure was available from reception, detailed in the patient leaflet and on the patient website. Staff we spoke with were aware of their role in supporting patients to raise concerns. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 19 complaints received in the last 12 months and found that all had been addressed in a timely manner. When an apology was required this had been issued to the patient and the practice had been open in offering complainants the opportunity to meet with either the manager or one of the GPs.

The practice reviewed complaints annually to detect themes or trends. We looked at the audit for the last review and main theme of dissatisfaction with appointments had been identified. However, lessons learned from complaints had been acted on and improvements made to the quality of the service as a result. For example, fast track appointment system had been reviewed and seven and half minutes fast track appointment slots were replaced with minimum 10 minutes duration.

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 stated mission statement and the statement of purpose. The practice had a vision to deliver high quality care and promote good outcomes for patients. We found details of the aims and objectives were part of the practice's statement of purpose and strategy. We saw evidence that the practice objectives and future plans were regularly reviewed during quarterly strategic meetings.

The practice aims and objectives included working in partnership with patients and staff to provide the best primary care services possible. This also included providing a happy workplace where individuals feel valued and deliver high quality service to meet the specific needs of patients.

The practice informed us they had succession plan in place and were also considering how to deal with 11% increase in patient list size in last four years. The practice informed us that they were planning to recruit a new GP, care coordinator and a nurse. The practice had already recruited new nurses, practice manager and a pharmacist who was due to start in November 2015. The practice informed us they were considering to negotiate various options with developers for extending or reconstructing the current building site in order to meet the increased patients demand.

We spoke with fifteen members of staff and they all knew and understood the vision and objectives and knew what their responsibilities were in relation to these and had been involved in developing them. Our observations of staff receiving patients at reception and in taking phone calls from patients demonstrated that they placed the patient first in their day to day work.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice and hardcopies were also available in the administration office. We looked at six of these policies and all were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one partner was identified as lead for safeguarding. We spoke with sixteen members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. They told us that managers and GPs were approachable and listened to ideas for improving services and to any concerns they had.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for year 2014-15 had reflected that the practice was required to improve performance for patients with diabetes, chronic kidney disease and chronic obstructive pulmonary disease (COPD). However, we saw a diabetic care planning project producing good results and the practice was expecting improved outcomes for diabetic patients in next QOF data. The practice had planned to roll out this diabetic project at CCG level with one GP partner acting as Clinical Commissioning Group (CCG) diabetic lead. The practice informed us that they were planning to start similar care planning projects for patients with other long term conditions as well. There were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. For example, evidence from incidents and complaints was used to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had identified the operational risk with prescription security two weeks before our inspection. However, the practice was still in the process of implementing the change and working to develop written risk assessment and action plan, to ensure prescriptions were monitored, tracked and stored securely.

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. However, the governance systems were not always being effective. For example, the practice had not carried out follow up audit and risk assessment for infection control to identify risks and monitor continuous progress effectively.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, safeguarding and confidentiality) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on

Are services well-led?

Good

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

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.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that practice learning team meetings, reception team meetings, management team meetings, strategic meetings, nursing team meetings and the clinical team meetings were held on regular basis. 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 confidence in doing so and felt supported if they did. We also noted that team away days were held last year but still waiting dates for this year. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We looked at the results of the survey and noted actions were identified to improve the service. This was included in the survey report, which was available on the practice website. It had an active PPG which included representatives from various population groups. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). For example, the PPG undertook a disability assessment and actions were identified. Following the survey, a disabled toilet was provided near to the waiting room and automatic main entrance doors were installed.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. We also noted a green staff feedback board in the corridor and saw a positive feedback written by a locum GP. 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 four staff files and saw that regular appraisals took place which included a personal development plan. The staff training plan showed us that staff were required to complete mandatory training and that nurses were supported to attend relevant professional updates. Staff we spoke with told us about their personal development plans and we witnessed career progression among the staff team.

The practice had completed reviews of significant events and other incidents and shared with staff at monthly learning team meetings 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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found the registered person did not have suitable arrangements in place for assessing risks relating to health and safety and infection control. Regulation 12(2)(a)(b)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: We found the registered person did not have suitable arrangements in place for identifying, assessing and managing risks in order to protect the welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 13(1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: We found the registered person did not have suitable arrangements in place for assessing, monitoring and improving the quality and safety of services relating to infection control audit monitoring and national guidance

This section is primarily information for the provider

Requirement notices

was not followed in the security of prescriptions. Records must be managed safely and kept securely to ensure they are accurate and not accessible to unauthorised persons.

Regulation 17(2)(a)(b)(c)