

Wokingham Medical Centre

Quality Report

Wokingham Medical Centre, 23 Rose Street,
Wokingham RG40 1XS

Tel: 0118 978 4566

Website: <http://www.wokinghammedicalcentre.co.uk>

Date of inspection visit: 6 May 2015

Date of publication: 09/07/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9
Outstanding practice	10

Detailed findings from this inspection

Our inspection team	11
Background to Wokingham Medical Centre	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13
Action we have told the provider to take	26

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wokingham Medical Centre on 6 May and 10 June 2015. We re-visited the practice on 10 June due to concerns with medicine review data sent to us after the initial inspection visit. This was to identify if there were significant concerns to patient welfare and safety. Overall the practice is rated as requires improvement.

We inspected this practice in September 2014 and found concerns regarding governance and monitoring of the quality of the service. We issued a requirement notice. Specifically the practice was not ensuring communication between staff was always taking place when significant concerns were identified. Staff training was not being monitored properly. Changes to protocols and practice were not always made in response to events or concerns identified. During this inspection we checked to see if improvements in these areas had been made. Improvements had been made to the process of checking

test results and responding to incidents and concerns. Communication between staff had improved and training was being identified and monitored. However, we found some concerns regarding the monitoring of patients medicines and the storage of vaccines. Patients reported the appointment system sometimes caused problems for them in accessing appointments.

At this inspection we found the practice to be good for providing effective and caring services and for being well-led. The practice requires improvement in the safe and responsive domains. It also requires improvement for all of the six population groups we assessed.

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

- The practice partnership had moved to one single location in 2014.
- A purpose built practice was opened in 2014. The new building provided an accessible and modern practice with a broad range of facilities to meet patients' needs.

Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Significant events and complaints were fully investigated and led to changes in protocol and practice.
- Communication channels and regular meetings were available to all staff which enabled them to be involved in the running of the practice.
- Risks to patients were assessed and well managed including infection control, premises maintenance, equipment checks and emergency procedures.
- Medicines were checked and monitored to ensure they were safe but vaccines were sometimes stored at a temperature slightly above the maximum indicated by national guidance.
- Medicine reviews did not always take place within required timeframes to ensure ongoing treatment was appropriate.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- There was a system for following up test results and a buddy system to ensure urgent results were checked if GPs were absent.
- Staff training was identified, monitored and undertaken to ensure staff could fulfil their roles safely and effectively.
- Patient feedback showed 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.
- Survey data and feedback we received showed some patient dissatisfaction with the ability to see or speak with GPs, mainly associated with the appointment booking system. Some patients believed this impacted on their care.
- The GP call back system operated by the practice made it difficult for patients who had commitments such as work to speak with a GP as call back times were unpredictable and patients said they were not given a specific all back time-slot.
- The practice had modern facilities and was well equipped to treat patients and meet their needs.
- There had a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We found one area of outstanding practice:

The practice employed a nurse who worked in the local community, providing long term condition reviews, immunisations and other care to patients who found it difficult to travel to the surgery. This made accessing care and treatment much easier for patients who had limited mobility and long term health conditions.

There were areas of practice where the provider must make improvements.

- Ensure patients receive medicine reviews in line with the timeframes identified by the practice and in line with national guidance.
- Review the guidance used to monitor the storage of vaccines.
- Review the appointment system to ensure it meets the needs of all patient groups.

Additionally the provider should :

- Improve communication with the independent pharmacy located on site regarding prescriptions to avoid significant inconvenience to patients.
- Develop a programme of clinical audit which ensures changes to patient care are embedded where they are needed.

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?

The practice is rated as requires improvement for providing safe services. Systems to ensure medicines were stored correctly and within their date of expiry were not always effective. We noted 17 occasions when vaccines were stored at a temperature slightly above the recommended level in national guidance and appropriate action was not taken. An infection control policy was in place and followed. A disaster recovery plan was in place. Safeguarding training was provided and protocols were accessible for staff. There was evidence that staff acted on any concerns related to safeguarding. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Investigations into significant events ensured problems were identified and that lessons were learned to ensure improvements were made to the service. Risks to patients associated with premises and the provision of care were assessed and well managed. There were enough staff to keep patients safe

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were similar to the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Enhanced services were undertaken to prevent unplanned admissions. The practice had a system to ensure staff had received training appropriate to their roles and appraisals were in place to identify further training needs. Staff had an awareness of the Mental Capacity Act 2005 and supporting guidance was in place. Staff worked with multidisciplinary teams in planning and delivering care, such as liaison with district nurses and palliative care teams. There was no comprehensive system of completing clinical audits. Some medicines reviews were not undertaken within timeframes identified by the practice to ensure repeat prescriptions were appropriate. Immunisation rates were low but the practice had implemented a plan to improve these rates.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice well in several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services was

Good



Summary of findings

available. We also saw that staff treated patients with kindness and respect. Confidentiality was maintained and staff had an awareness of their role in maintaining privacy and preventing private information from being shared.

Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services. Many patients said it was difficult to make appointments face to face and some were concerned about the quality of their care as a result. The practice operated a GP call back system which many patients reported was difficult for them if they had other commitments such as work due to unpredictability in when call backs would take place. Patients reported that online booking was not always available. The practice was aware of the needs of its local population, including those who needed additional support in receiving the care and treatment they needed. Call waiting times were monitored. The practice had modern and well planned facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice acknowledged, investigated and responded to patients' complaints appropriately.

Requires improvement



Are services well-led?

The practice is rated as good for being well-led. The new partnership had delivered a new building for its patient population in 2014. Further consideration about future demands and changes were discussed and considered by the partnership team and management. There was a clear leadership structure and staff felt supported by management and partners. The practice had policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk, such as monitoring of the patient call waiting times. The practice proactively sought feedback from staff and patients. Monitoring of medicine reviews did not always take place. The clinical audit programme was still in development. The patient participation group (PPG) was a virtual reference group and a physical group, but these were still being developed. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as requires improvement for the provision of safe and responsive services. The concerns that led to these ratings affect all the population groups. Monitoring of patients' repeat prescriptions was not adequate as it did not identify when they passed dates set for medicine reviews. Vaccines were not always stored appropriately. Difficulty in seeing a GP was a concern raised by patients who required ongoing care and treatment. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered 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. It offered home visits and employed a practice nurse who visited older patients to administer flu vaccinations and undertake health checks when appropriate.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the provision of safe and responsive services. The concerns that led to these ratings affect all the population groups. Monitoring of patients' repeat prescriptions was not adequate as it did not identify when they passed dates set for medicine reviews. Vaccines were not always stored appropriately. Difficulty in seeing a GP was a concern raised by patients who required ongoing care and treatment. Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available when needed. All these patients had a named GP and were offered a structured annual review to check that their health needs were being met. However we found that medication reviews were not always completed. Six out of 10 of the repeat prescriptions produced on the day of inspection were for patients who had not received a medicine review. The practice achieved 69% of flu vaccinations for those patients in this group that were eligible. This was below the local average. 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. Some patients reported finding it difficult to see a GP and some were concerned about the reviews of their medical conditions as a result.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the provision of safe and responsive services. The concerns that led to these ratings

Requires improvement



Summary of findings

affect all the population groups. Difficulty in seeing a GP was a concern raised by patients who required ongoing care and treatment, potentially a concern to mothers with babies and young children. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children on the at risk register. Immunisation rates met the national 90% target for all standard childhood immunisations. The practice undertook mother and new baby health checks at the same time as first baby immunisations. This avoided two appointments and supported achievement of the targets for baby immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. However, the patient call back system operated when someone requested an appointment could be difficult due to the lack of a specific call back timeframe. We saw good examples of joint working with midwives and health visitors. A counselling service for young people was available on site and the practice promoted chlamydia screening.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the provision of safe and responsive services. The concerns that led to these ratings affect all the population groups. The needs of the working age population, those recently retired and students had been identified, but not always met. The practice offered telephone consultations and extended hours. However, the patient call back system did not provide consistent call back times for patients, causing particular problems for those who worked full time. The practice was not dealing with these concerns. The practice offered online repeat prescribing but patients told us there were problems using the online appointment system. A full range of health promotion and screening was provided that reflected the needs for this age group. Patients who wished to check their own blood pressure and their weight and height were encouraged to do so and the results were reviewed by the health care assistant.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the provision of safe and responsive services. The concerns that led to these ratings affect all the population groups. Monitoring of patients' repeat prescriptions was not adequate as it did not identify when they passed dates set for medicine reviews. For patients who do not attend the practice regularly due to their circumstances or lifestyles this posed a risk. Vaccines were not always stored appropriately. The practice held a register of patients living in vulnerable circumstances including homeless people, those with a learning disability and

Requires improvement



Summary of findings

carers. It offered health checks for patients with a learning disability but only just over 50% had received their health check in the last year. It offered longer appointments for people with a learning disability. Staff received training in equality and diversity and interpreter services were available for both patients whose first language was not English and patients who needed sign language interpretation.

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

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the provision of safe and responsive services. The concerns that led to these ratings affect all the population groups. Monitoring of patients' repeat prescriptions was not adequate as it did not identify when they passed dates set for medicine reviews. Vaccines were not always stored appropriately. Difficulty in seeing a GP was a concern raised by patients who required ongoing care and treatment. 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 and one of the GPs took a lead in supporting patients living with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on conflict resolution and in caring for this group of patients. There was evidence of close working with community teams specialising in supporting this group of patients and the practice had access to talking therapy services.

Requires improvement



Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 81 patients undertaken by the practice in 2015. We also considered evidence from the feedback we received on the day from 17 patients and 30 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 92% of practice respondents said the GP was good at listening to them and 89% said the GP gave them enough time. Eighties five per cent said the last nurse they saw or spoke to was good at listening to them and 86% said the last nurse they saw or spoke to was good at giving them enough time. The survey also identified 100% of respondents had confidence and trust in the last nurse they saw or spoke to. Over 70% of patients felt treated with dignity and respect.

The majority of feedback from patients suggested the practice offered a caring and helpful service. Some comments were less positive and these related to patients who felt they found it difficult to see a GP face to face and were treated or prescribed medicine over the phone. The patients who provided negative feedback on this issue suggested this meant there was a less caring service than if face to face appointments. Eighty three per cent of patients said the last GP or nurse they saw treated them with care and concern.

The GP national patient survey found 76% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 84% said the last nurse they saw or spoke with was good at involving them in decisions about their care. The practice survey found that 55% of patients felt involved in decisions about their care, with only 2-3% reporting involvement in decision making was poor on the survey.

In the 2014 GP survey 75% of patients reported good overall experience of making an appointment, the same as the national average. Only 78% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to 89% nationally. The practice survey identified that 68% of patients found the appointment system good or quite good, with 32% stating it was not very good or not at all good. Feedback we received from patients suggested that some patients were unhappy with the appointment system due to the need for a call back from a GP. Patients reported that there was no set time for a call back and for patients with commitments such as work where they could not pick up the phone this provided a restriction in accessing the service. Some patients reported trying to make an appointment for two days. There was some feedback that the lack of face to face appointments was impacting on the care patients received. One patient reported they simply had their medicines repeated without ever seeing a GP. Another patient reported they were prescribed medicines over the phone and felt this was inappropriate.

Areas for improvement

Action the service **MUST** take to improve

- Ensure patients receive medicine reviews in line with the timeframes identified by the practice and in line with national guidance.
- Review the guidance used to monitor the storage of vaccines.
- Review the appointment system to ensure it meets the needs of all patient groups.

Action the service **SHOULD** take to improve

Improve communication with the independent pharmacy located on site regarding prescriptions to avoid significant inconvenience to patients.

Develop a programme of clinical audit which ensures changes to patient care are embedded where they are needed.

Summary of findings

Outstanding practice

The practice employed a nurse who worked in the local community, providing long term condition reviews,

immunisations and other care to patients who found it difficult to travel to the surgery. This made accessing care and treatment much easier for patients who had limited mobility and long term health conditions.

Wokingham Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist adviser, a practice nurse, practice manager and two other CQC inspectors.

Background to Wokingham Medical Centre

Wokingham Medical Centre is located in the town centre of Wokingham. The practice premises were purpose built and opened in 2014. The new building provided an accessible and modern practice with a broad range of facilities to meet patients' needs. It is open from 8am to 6.30pm. Patients are registered from the town and local rural areas. The practice population has a high proportion of patients in local care homes (240). There is minimal deprivation according to national data.

We inspected this practice in September 2014 and found concerns regarding governance and monitoring of the quality of the service. We issued a requirement notice. Specifically the practice was not ensuring communication between staff was always taking place when significant concerns were identified. Staff training was not being monitored properly. Changes to protocols and practice were not always made in response to events or concerns identified. During this inspection we checked to see if improvements in these areas had been made.

Improvements had been made to the process of checking test results and responding to incidents and concerns. Communication between staff had improved and training was being identified and monitored. However, we found some concerns regarding the monitoring of patients

medicines and the storage of vaccines. We re-visited the practice on 10 June due to concerns with medicine review data sent to us after the initial inspection visit. This was to identify if there were significant concerns to patient welfare and safety.

Approximately 23,000 patients are registered with the practice.

Care and treatment is delivered by 10 GP partners, two salaried GPs, with seven male and five female GPs, 12 members of nursing staff including practice nurses, nurse practitioners and health care assistants. There is a management team, administration and reception staff.

The practice is a member of Wokingham Clinical Commissioning Group. We visited Wokingham Medical Centre, 23 Rose Street, Wokingham RG40 1XS as part of this inspection.

This practice was going through the process of being accredited as a training practice. The practice had a General Medical Services (GMS) contract. GMS contracts are directly negotiated between the General Medical Council and the practice.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider and NHS 111.

Why we carried out this inspection

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

Detailed findings

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 provider had not been inspected before under the new methodology and that was why we included them.

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

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), local Healthwatch, NHS England and Public Health England. We visited Wokingham Medical Centre on 6 May and 10 June 2015. During the inspection we spoke with GPs, nurses, members of the management team, a member of the patient participation group, administration and reception staff. We obtained patient feedback from speaking with patients, comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and

audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with was aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a nurse reported when they had administered an injection ahead of schedule. The incident was investigated the practice ensured patient safety had not been compromised and nurses received to check administration dates before giving injections. The learning was discussed, recorded and disseminated.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record. National patient safety alerts were disseminated by the practice manager to all relevant staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every six 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. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they told us they would not hesitate to do so. We reviewed further records that showed the practice randomly selected significant events that had occurred in the past to check that the actions that had been identified at first review had been completed. For example a review in March 2015 covered three incidents that had taken place in 2014. We saw that a protocol required for an event in 2014 had been checked and was in place.

Staff reported incidents to their line manager or the practice manager who completed incident forms and placed them on the agenda for investigation and

discussion. We looked at the system used to manage and monitor incidents. We reviewed the records of 16 incidents and found they were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a team of staff were identified with the responsibility to chase up test results from hospital in response to results not being sent to the new practice address. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, vulnerable young people and vulnerable adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked GPs, nurses 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had received level three safeguarding training related to this role. All staff at the practice had completed appropriate levels of safeguarding training related to their role. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place. (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). Chaperone training had been undertaken by all staff undertaking chaperone duties. Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to observe the examination and what to do if they had any concerns regarding the examination.

There was a system and computer coding to highlight vulnerable patients on the practice's electronic records.

Are services safe?

This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or patients with learning difficulties.

Medicines management

We found that all medicines stored onsite were within their expiry date and stored securely. Each nurse was responsible for the monitoring medicines in their consulting rooms and two nurses covered medicine checks during absences and holidays. Fridge temperatures were monitored but did not follow guidance on what temperature range was appropriate to keep the medicines active and functional. We saw from the practice records of fridge temperatures that there had been 17 instances where a fridge had been slightly over the maximum temperature according to national guidance. Although this posed a minimal risk to the vaccines, no action had been taken to prevent this from happening despite the numerous occurrences. A nurse told us an external professional had been brought into the practice to review the practice's storage of vaccines. They said they were keen to prevent freezing vaccines as this was a high risk to the potency of the drugs. However, the practice should ensure that vaccines are consistently stored within the correct range and have protocols in place to take action when variation outside this normal range occurs. Reception staff told us they would immediately call for a nurse on receipt of vaccines to ensure the cold chain (correct storage temperature) was maintained.

There was a protocol for repeat prescribing. Five out of nine patients who used the repeat prescribing service told us they had poor experience. They told us they were often told the prescription would be ready by the practice and then find it had not been passed to the independent pharmacy located on site for collection when they went to collect it. Repeat prescribing within the practice was meant to be monitored via a review date set for number of repeat prescriptions a patient could have before a review was needed by a GP. We saw some prescriptions were repeated past the review date without a review taking place. A sample count of 10 prescription requests identified six were overdue a medicine review. GPs told us they would be prompted if a patient needed a medicine review related to their condition when they reviewed the patient's notes. However, this relied on periodic contact with a GP which might not be expected for a long period of time depending

on what conditions the prescriptions were used to treat. Following the inspection the practice reviewed how many patients were overdue medicine reviews in 2014/15 and found 44% were overdue their reviews. We revisited the practice on the 10 June and found that the system for identifying when patients needed a repeat prescribing review could mean multiple dates were noted on their records. This made monitoring medicine reviews difficult for the practice. We looked at eight patients who on the computer records system and found three out of eight were overdue medicine reviews, all by under two months. There was a system for reviewing patients' medicines but the practice had not identified that this was not working effectively until the inspection. This meant some patients may be taking medicines which did not meet their treatment needs or which could be potentially unsafe. On 10 June the practice was able to show us they had begun to synchronise medicine review dates for all the medicines patients were taking, making the reviews easier to identify and complete, but this would take many months to complete.

Nurses administered medicines with the appropriate authorisation of GPs through written directives. Blank prescription forms and prescription pads were handled in accordance with national guidance and kept securely at all times.

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 risk of infection.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Records showed us that staff had received relevant training on infection control including updates on hand washing techniques. Staff told us and records confirmed that understanding their role in reducing the risk of cross infection was included during induction. For example, reception staff explained their role in safe receipt of specimens. We saw evidence that the lead had carried out audits of infection control and some specific areas for

Are services safe?

example auditing how clinical waste was dealt with and that appropriate hand washing procedures were being followed. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice was located in a new building and therefore the risk of legionella was minimal due to the water systems being new.

Equipment

The practice employed a premises and facilities manager to ensure the building and essential building services were maintained. We saw that the premises were in good condition. 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 records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

Records we reviewed contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. There was a health and safety policy and this was supported by a range of risk assessments such as manual handling and access to the building.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of 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

Are services safe?

sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records

showed that staff were up to date with fire training. We saw that fire fighting equipment and the fire alarm system had been serviced in accordance with manufacturer's instructions.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence that new guidelines were disseminated and that the practice's performance was reviewed where necessary. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw evidence that NICE guideline were referred to following a significant event to make staff aware of the best practice guidelines related to the clinical care being provided.

The GPs led in clinical areas such as diabetes and respiratory diseases. Nurses received training to enable them to lead in specific long term conditions. This enabled the practice to effectively manage specific long term conditions. Clinical staff we spoke with was open about asking for and providing colleagues with advice and support. We completed a review of templates used to review patients with various long term conditions. These reflected national guidance.

Care plans were created for patients at risk of unplanned admission to hospital as part of an enhanced service (a funded service beyond the contractual obligations of the practice). This was aimed at reducing hospital admissions and caring more effectively for patients in communities. There was a process for following up on information and any care needed by patients discharged from hospital. Information was stored on the patient record system and flagged for follow up by a GP. Most patients who may need additional support due to their conditions or circumstances were flagged on the record system.

There was a register of patients with a learning disability and 51% of these patients had a health check within the last year. Out of 129 patients who had suffered from a specific mental health problem, 73 had care plans.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses

showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had 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 showed us clinical audits which had been undertaken since the practice was formed in 2014. The programme of clinical audit across the practice was still being formulated and there was only a year of data for us to review. Audits were undertaken in response to medicines management information, trainee GP's learning needs, 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 had not repeated most of these audits. Outcomes were not always shared widely with staff to promote learning. Nurses were not regularly involved in audit outcomes, but did undertake some audits themselves.

The practice used data to identify improvements, such as QOF. For example, some data regarding diabetic checks indicated low scores compared to the national average. The practice was changing the way it involved patients in diabetic reviews to try and engage them and motivate better self-care and uptake of health checks. Child immunisation rates had been low in the previous year and so the practice dedicated a nurse to improving child immunisation uptake. The most recent data showed the practice was matching the national average.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed well on QOF across the majority of clinical outcomes for patients achieving 97% overall in 2014/2015.

Referrals were audited to determine whether alternatives were available and if they were appropriate after the referrals had taken place.

Are services effective?

(for example, treatment is effective)

When test results, such as tested blood specimens, were received by the surgery from laboratories, the practice logged these and allocated them to a GP who requested the test. To mitigate the risk of a delay in test result reviewing, a deputy was allocated for each GP who would access test results which may need action taken. To ensure that any test results which may have been allocated to the wrong practice or to another GP were followed up, GPs had a means of chasing and obtaining results. Nurses did not have access to this function. This meant some test results could not be tracked if requested by a nurse.

The practice monitored its prescribing data. We reviewed this and saw that prescribing of specific medicines that were audited, such as anti-biotics, were within acceptable levels.

The practice had implemented 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.

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 training courses such as annual basic life support and safeguarding. There was a training log which identified what training was required by staff and when this would need to be updated. We noted a good skill mix among the GPs and nurses. All the GPs attended local meetings to discuss clinical topics with other GPs and share learning. 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).

The practice had training plans for different staff roles which included various aspects of training specific to the practice's policies and protocols. All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff

confirmed that the practice was responsive when staff identified training needs they were supported and funded for relevant courses. Nurses attended courses for the care of specific conditions.

Working with colleagues and other services

The practice worked with other service providers to provide patients' care including those with complex care 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 worked with the district nursing team, health visitors and midwives. GPs told us there was a multi-disciplinary team meeting regularly. This included the district nurses, health visitors and palliative care nurses. The minutes of the meetings showed us that care of patients that required the input from various staff was discussed to ensure co-ordinated care was given. There was evidence of working with other healthcare professionals and voluntary bodies. A pilot was run in partnership between the local ambulance service and the practice to help provide patients who needed morning home visits. This benefitted patients who required non-urgent home visits, as usually, these can only be organised from midday onwards due to the commitments of GPs. This provided care that was specifically required in the morning by some patients.

Information sharing

The practice used electronic systems to communicate with other providers and internally. Care planning for patients who may need additional support, such as those receiving end of life care, was linked to external services such as out-of-hours providers. This was designed to ensure patients with care plans would have their preferences and treatment plans considered when receiving out-of-hours care. Electronic systems were also in place for making referrals.

The practice had systems to provide staff with most of the information they needed. Staff used an electronic patient record system to 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

Are services effective?

(for example, treatment is effective)

future reference. Patients who had care plans due to the risk of admission to hospital had their care plans stored on the main patient record system and were shared with the local out of hours service.

Consent to care and treatment

We found that GPs and nurses were aware of the Mental Capacity Act 2005. All the staff we spoke with understood the key parts of the legislation. We saw evidence of staff gaining consent from patients for specific procedures, such as minor surgery.

The practice had set up a register to identify patients who had deprivation of liberty (DoLs) assessments, which lawfully enabled care or nursing homes to prevent certain liberties for individual patients based on the risk they posed to themselves. The practice had tried to work with local care homes to ensure this list was up to date. This enabled the practice to monitor their patients who may have DoLs orders which may impact on their care.

Staff were aware of the Gillick Competencies (this refers to the rights of children to make decisions about their treatment between the ages of 13-16). Staff told us they were aware of their responsibility to gain consent from patients and we saw evidence in patient records that consent was discussed.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant (HCA) to all new patients registering with the practice. In the last year 226 patients (6%) of all new patients registered attended new patient checks. Any health concerns identified were passed on to the GPs or practice nurses for action. The practice provided facilities for patients to take their own height, weight and blood pressure measurements and during certain times there were patient helpers available to assist patients to use the equipment. New patients who did not attend a check with the HCA were encouraged to submit their own

measurements and to complete an alcohol consumption scoring tool. The results of self assessment were checked and if they exceeded a specific score the patient was contacted to attend an appointment with the HCA.

The practice actively promoted smoking cessation. There were display stands at the entrances to waiting rooms with a variety of material promoting the benefits of stopping smoking. Practice data showed that 82% of smokers had been actively offered smoking cessation advice in 2014. The practice was visited by a specialist team who worked with patients wishing to quit smoking. We noted that 2.5% of the patients identified as smokers in 2014 had quit.

The practice offered a full range of immunisations for children. The most recent data available showed the practice achieved the 90% national target for both baby immunisations and immunisations at the age of five. We noted that the practice did not achieve the challenging target of 95%.

Pneumococcal vaccinations had been taken up by 2372 of the 2771 (86%) of patients who were eligible. Thirty four per cent of the patients eligible for a shingles vaccination had taken up the offer of the vaccination. Last year 77% of those aged over 65 received flu immunisation. This was slightly below the local average as was the 69% flu immunisation rate for patients with long term conditions. The practice employed a practice nurse who visited patients who found it difficult to attend the practice to administer their flu immunisations.

The practice offered other health screening opportunities. Data showed that 7.3% of patients attended for bowel screening, breast screening was taken up by 16.4% of the eligible patients and 14% of young patients who were eligible took chlamydia tests.

There was health promotion material available in the waiting area. This included information on dementia services, avoiding hypothermia, spotting early signs of cancer and carer's information.

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 and a survey of 81 patients undertaken by the practice in 2015. We also considered evidence from the feedback we received on the day from 17 patients and 30 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 92% of practice respondents said the GP was good at listening to them and 89% said the GP gave them enough time. Eighty five per cent said the last nurse they saw or spoke to was good at listening to them and 86% said the last nurse they saw or spoke to was good at giving them enough time. The survey also identified 100% of respondents had confidence and trust in the last nurse they saw or spoke to. Over 70% of patients felt treated with dignity and respect.

The majority of feedback from patients suggested the practice offered a caring and helpful service. Some comments were less positive and these related to patients who felt they found it difficult to see a GP face to face and were treated or prescribed medicine over the phone. The patients who provided negative feedback on this issue suggested this meant there was a less caring service than face to face appointments. Eighty three per cent of patients said the last GP or nurse they saw treated them with care and concern.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Some consultation rooms had privacy areas where patients could change before and after examinations. Windows were designed to prevent anyone outside seeing into treatment or consultation rooms. 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. The reception desk

was located away from the waiting area to reduce the risk of patients overhearing conversations at the reception desk. Calls were taken in a back office to ensure patients could not overhear potentially private phone conversations.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatment so that confidential information was kept private.

Care planning and involvement in decisions about care and treatment

The GP national patient survey found 76% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 84% said the last nurse they saw or spoke with was good at involving them in decisions about their care. The practice survey found that 55% of patients felt involved in decisions about their care, with only 2-3% suggestions involvement in decision making was poor.

Staff told us that translators were available to be booked for patients who did not have English as a first language to enable them to discuss and be involved in their care and treatment.

Patient/carer support to cope emotionally with care and treatment

A bereavement service was promoted by the practice to support patients through loss of people close to them. The practice survey found that over 65% of patients felt they were treated with care and concern. Leaflets in waiting areas informed patients of how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Support services for patients with mental health conditions were promoted by the practice.

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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The diversity of the practice population was understood by staff within the practice and systems were in place to address identified needs in the way services were delivered. This included the numbers of patients who may be in vulnerable circumstances such as homeless, deaf or physically disabled patients. The practice kept a record of consultations with patients who were potentially vulnerable, such as deaf or homeless patients. There were 240 patients cared for in care or nursing homes by the practice. There was access to interpreters for deaf patients.

Reception staff told us there was live monitoring of the appointment system to determine whether the phone wait times were becoming longer due to capacity and staff could be brought in to deal with calls from other tasks. We saw patient helpers were available near reception to assist patients in accessing their services and navigating their way around the building. There were "sub" waiting areas which were designed to provide a private waiting space for patients who may want to be away from other patients, such as breast feeding mothers. There was no clear signage at the entrance to the practice car park to make it clear to patients how to gain access to the building or car park. Some signs within the practice were written in a small font making it difficult to see for patients with impaired or poor vision.

The practice employed a nurse who worked in the local community, providing long term condition reviews, immunisations and other care to patients who found it difficult to travel to the surgery. Home GP visits were available.

Saturday clinics were provided during the winter from January to March 2015 to improve access for working patients. Staff told us the uptake from working patients was not particularly high.

Height adjustable benches, which made it easier for patients who had limited mobility, were available in consultation rooms and the practice had ordered more of these to increase accessibility of services within different treatment rooms within the practice.

Patients who required travel immunisations or health advice could receive this at the practice. Time was allocated for visits to a local nursing by a single GP on a weekly basis and when required. GPs told us having one GP providing this service improved continuity of care.

Communication with patients was not always adequate. For example, patients we spoke with were concerned about the lack of consistency in their prescriptions, as some of them reported that the practice would inform them their prescriptions were ready and find they were not when they went to collect them. Some patients were concerned that a change in maximum prescriptions had taken place. This was in response to local prescribing guidance that the practice adhered to. However, patients we spoke with were not aware of why the change had taken place and complained of how this had impacted on their care. For example, one patient usually had two months of inhaler provided for their asthma but this reduced to one month which they said caused difficulties for them.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services including a phone translation service. This made it easier for patients with urgent concerns who did not speak English to access care and treatment at the practice. Staff told us that there were very few non-English speaking patients. The building had been designed to enable patients with limited mobility to access services. A disability access audit was undertaken to identify areas of improvement. The front of the building had level access for wheelchairs. Wide doorways and corridors enabled patients with wheelchairs and mobility scooters to access the building. There was a lift to access services on different floors. A hearing aid loop was installed.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was a room which could be used for breast feeding mothers.

Access to the service

Appointments were available from 8:30am to 6pm. A GP call back system was operated, meaning if a patient called the practice for an appointment a GP would call them back

Are services responsive to people's needs?

(for example, to feedback?)

to determine if they needed an appointment, phone consultation or another service. If a patient stated their need was urgent staff said they would be prioritised for a call back. Patients could book appointments in advance or for the same day in person or on the phone. Patients reported that the online booking system was not working properly at the time of the inspection, but had been set up in the past. Saturday morning extended hours appointments were available during the winter. The practice arranged extended hours appointments by request. The days and times for of these extended hours were not provided on the practice website. .

In the 2014 GP survey 75% of patients reported good overall experience of making an appointment, the same as the national average. Only 78% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to 89% nationally. The practice survey identified that 68% of patients found the appointment system good or quite good, with 32% stating it was not very good or not at all good. Feedback we received from patients suggested that some patients were unhappy with the appointment system due to the need for a call back from a GP. Patients reported that there was no set time for a call back and for patients with commitments such as work where they could not pick up the phone this provided a restriction in accessing the service. Some patients reported trying to make an appointment for two days. There was some feedback that the lack of face to face appointments was impacting on the care patients received. One patient reported they simply had their medicines repeated without ever seeing a GP. Another patient reported they were prescribed medicines over the phone and felt this was inappropriate. There was a risk patients' treatment was not appropriate or safe.

The practice monitored call waiting times. This provided the longest wait times for patients calling the practice and also the average. For example, on week beginning 16 March the audit tool captured 90% of 3593 incoming calls and the longest wait for an answer was nine minutes 12 seconds, with average wait to answer around one minute. The week beginning 13 April captured 87% of 3946 incoming calls. The longest wait for answer was 13 minutes 34 seconds, with average wait to answer of over a minute. This suggested the average wait time for a call was reasonable, but the longest wait time did not indicate how frequent

such a wait was. This tool did enable the practice to monitor access their phone lines over time. However, the national patient survey showed 81% found it easy to get through to this surgery by phone.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who required them, by a named GP and to those patients who needed one.

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. Complaints relating to clinical practice were handled by one of the GPs.

We saw that information was available to help patients understand the complaints system. The complaints procedure was displayed on the practice website, in the practice information leaflet and was available at the reception. When a patient lodged a complaint they received an acknowledgement and a copy of the practice's most up to date complaints procedure.

We looked at 15 complaints received since January 2015. We found that all of the complaints received in 2015 had been investigated in accordance with the practice complaints procedure. Thirteen of the complaints had been responded to in a timely manner and when something had gone wrong the patients was offered an apology. However, two complaints we reviewed had not been responded to within a month of receipt. We noted that in both cases the complaint had been investigated and a full and thorough response provided. Records showed that when complaints had been referred to a second stage of the complaints process that the practice co-operated with the relevant complaints review body and provided information requested in a timely manner.

Are services responsive to people's needs? (for example, to feedback?)

We also reviewed the practice complaints summary for 2014. This showed the practice had responded to all complaints received and followed their complaints procedure. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and this identified an increase in complaints relating to clinical matters and administration processes. It also identified a reduction in complaints about the appointments system. There was no evidence of a trend within the complaints concerning clinical practice. Staff we spoke with told us that the nature and outcome of complaints were shared with them via their team briefings

and team meetings. They were able to describe the changes in procedures that had taken place in response to complaints and how they worked to avoid recurrence of incidents and practices that gave rise to complaints.

We noted that during 2014 nineteen patients posted negative comments regarding the practice on the NHS choices website. There were also 13 postings of positive feedback. The practice did not respond to all the comments posted on NHS choices. However, staff we spoke with were aware of the feedback on this website and told us they took account of patient comments in the way they conducted their duties.

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 vision in how it was to deliver care to its patients. These were listed on the website and included providing first class primary care and ensuring professional, friendly, well trained staff, plus same-day access. The planning and delivery of a new building was funded by the partnership. The new building was opened in 2014 and architectural award for its design in relation to delivering healthcare. There was long term planning for the practice to be able to deliver care to a patient population of 30,000. The practice had a plan to recruit more clinical staff to increase its capacity but partners and the practice manager told us finding the quality of staff the practice wanted was proving difficult.

Governance arrangements

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

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. The leads in these areas had their roles clearly defined.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at staff meetings. Two staff members led on QOF outcomes. If one area of QOF was a potential concern then the practice would delegate responsibility to the lead GP in that area of care or clinical management. The practice did not have any 2014 QOF data due to the merger of the two practices in 2014.

The practice had clinical audits which it used to monitor quality. However, the audit programme was in development and the practice had not begun to complete audit cycles in order to identify whether improvements were being made in practice.

The practice had arrangements for identifying, recording and managing risks. There was comprehensive documentation and assessment of potential risks to the daily running of the practice. These included a fire risk assessment, drills and fire training provided to staff.

Leadership, openness and transparency

We saw minutes from partnership meetings and monthly clinical and regular multi-disciplinary meetings. Staff were able to attend a meeting regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or to their line manager or a GP if required. Staff we spoke with knew who to report concerns to about specific issues such as safeguarding and also had line managers to ensure they knew where they could access support if needed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and used external feedback from the national GP survey. However, concerns from patients about the GP call back system and difficulty in accessing appointments or receiving face to face care had not been identified or acted on. Patients reported to us that the system did not work well. The leadership team were aware the system was unpopular with some patients and a review of the appointment system was undertaken in November 2014. This has led to changes in the number of same day appointments available from April 2015. However, this plan did not include action regarding patients' concerns at not being able to speak with GPs as part of the call back system when requesting appointments.

The practice had a Patient Participation Group (PPG) and a virtual PPG. The PPG members we spoke with stated the group was quite new and recruitment was still ongoing. They said that the practice engaged with them and the practice manager attended their meetings. The virtual group was communicated with surveys from the regional CCG forum.

The practice had gathered feedback from staff through meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a

Are services well-led?

Good 

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

whistleblowing policy which was available to all staff. An away day was held in 2014 and another was planned for GPs and some management staff. The practice closed for half a day every month for a learning day and staff were encouraged to contribute ideas for the practice's development and improvements.

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 several staff files and saw that

regular appraisals took place. Staff told us that the practice was very supportive of training and that they could attend external training events. Nurses told us their training plans were based on the needs and strategy of the practice.

The practice was going through the process of being accredited to be a training practice at the time of this inspection.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. Actions were disseminated and random checks of significant events were undertaken to check that actions designed to improve safety were embedded.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure safe care and treatment was being provided by assessing the risks to the health and safety of service users receiving treatment in the form of repeat prescriptions. Medicines were not always properly and safely managed. . Regulation 12(1)(2)(a)(b)(g)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	