The Billesdon Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 The Billesdon Surgery on 19 July 2016. The purpose of this inspection was to ensure that sufficient improvement had been made following the practice being placed in to special measures as a result of the findings at our inspection in September 2015 when we found the practice to be inadequate overall. Overall the practice is now rated as good.

At this most recent inspection we found that extensive improvements had been made and specifically, the ratings for providing an effective and well led service had improved from inadequate to good and the rating for providing a safe service had improved from inadequate to requires imiprovement. The rating for providing a responsive service had improved from requiring improvement to good and the rating for providing a caring service remained good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Overall, risks to patients were assessed and well managed with the exception of the repeat prescribing process. Action was taken on the day of our inspection to rectify the issue identified in this area.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- 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.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

Ensure effective systems and processes are in place relating to medicines management, including dispensary SOPs containing all necessary information, secondary thermometers for the medicine refrigerators being set in line with the practice policy, the protocol for methotrexate prescribing being followed and the changes to the repeat prescribing process embedded and followed.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by this service.

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.

- There was a system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had processes and practices in place to keep patients safe and safeguarded from abuse.
- On the whole, risks to patients were assessed and well managed. However on the day of our inspection we found that the repeat prescribing process was not in line with national guidance and the practice had not followed their own protocol for high risk prescribing. The practice immediately changed their process to rectify this.

Are services effective?

Good

The practice is rated as good for providing effective services.

- The most recent unpublished data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average and had improved on the previous year's results.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff. However some required a more detailed record.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey published in January 2016 showed 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice responded positively to findings at our last inspection and extensive improvements had been made.
- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents.
- The practice proactively sought feedback from staff and patients, which it acted on. There was a newly formed patient participation group.
- There was a focus on continuous learning and improvement at all levels.

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.
- The practice was responsive to the needs of older people, and offered home visits, longer appointments and urgent appointments for those with enhanced needs.
- At risk patients were discussed at a monthly multidisciplinary meeting.
- The practice had active engagement with the local Neighbourhood team.
- The elderly population were represented on the Patient Participation Group.

An anticoagulation service was offered to housebound patients and coordinated through the district nursing team.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- The practice had identified that improvements needed to be made in the areas of asthma and Chronic Obstructive Pulmonary Disease (COPD) and had taken action to improve the system for reviewing these cohorts of patients. For example the QOF results for 2014/15 showed that 74.6% of patients with COPD had received a review but the unpublished 2015/16 QOF results reflected that 92% of this group had received a review.
- Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Summary of findings

- 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.
- The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 83% and the national average of 82%.
- Appointments were available flexibly outside of school hours.
- We saw positive examples of joint working with midwives, health visitors and school nurses including their attendance at monthly safeguarding meetings.
- The practice provided a daily walk in open surgery.
- The practice participated in health promotion campaigns such as nasal flu and rotavirus.
- Chlamydia screening was available.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided a daily open surgery.
- Telephone consultations were available on a daily basis with patients able to specify the time of their choice.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group in order to prevent or identify conditions.
- A regular family planning clinic was held at the practice.

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.
- There was a learning disability lead within the practice and longer appointments were available for patients with a learning disability. Annual learning disability reviews were carried out.

Summary of findings

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 235 survey forms were distributed and 130 were returned. This represented 1.9% of the practice's patient list.

- 99% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 95% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 92% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 90% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 14 comment cards which were all positive about the standard of care received. Patients expressed their appreciation of the open surgery facility and described the service as excellent and the staff as caring, professional, friendly and thorough.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were courteous, conscientious and caring.

Areas for improvement

Action the service MUST take to improve

Ensure effective systems and processes are in place relating to medicines management, including dispensary SOPs including all necessary information, secondary thermometers for the medicine refrigerators being set in line with the practice policy, the protocol for methotrexate prescribing being followed and the changes to the repeat prescribing process embedded and followed.

The Billesdon Surgery

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 GP specialist adviser, a second CQC inspector and a practice manager specialist adviser.

Background to The Billesdon Surgery

The Billesdon Surgery is a GP practice which provides a range of primary medical services to around 6,800 patients from a main surgery in the village of Billesdon in Leicestershire and a branch surgery in Bushby, Leicestershire. The practice's services are commissioned by East Leicestershire and Rutland Clinical Commissioning Group (CCG). The practice has a dispensary which dispenses medicines to over 53% of patients registered with the practice.

The service is provided by two full time male GP partners, one female GP partner, one part time female partner and a part time female salaried GP who provide a total of 37 sessions per week. There are also three part time practice nurses, two part time health care assistants, a dispensary manager, two dispensers and two trainee dispensers. They are supported by a practice manager, a business manager, an information officer and reception and administration staff.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has one location registered with the Care Quality Commission (CQC). The location we inspected was Billesdon Surgery, 4 Market Place, Billesdon, Leicester. LE7 9AJ

The practice also has a branch surgery at Hill Court, Main Street, Bushby, Leicester. LE7 9NY which we did not visit as part of this inspection.

The main surgery is in a two storey building with a car park which includes car parking space designated for use by people with a disability. All patient facilities were on the ground floor. The branch surgery is on the ground floor of a building which the practice rent from the East Midland Housing Association. It also has parking at the front of the building.

We reviewed information from East Leicestershire and Rutland CCG and Public Health England which showed that the practice population had much lower deprivation levels compared to the average for practices in England.

The main surgery is open between 8.30am and 6.00pm Monday to Friday with open surgery from 8.30am to 10.00am and pre booked GP appointments from 2.00pm to 6pm. Pre-bookable nurse appointments are available between 9.50am and 12.30pm and 3pm and 6pm each day. The branch surgery is open between 8.30am to 12.30pm Monday to Friday and from 4.00pm to 6.00pm on Mondays.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided to Leicester City, Leicestershire and Rutland by Central Nottinghamshire Clinical Services.

In September 2015 we had carried out a comprehensive inspection of this service under Section 60 of the Health

Detailed findings

and Social Care Act 2008 as part of our regulatory functions At that inspection we found the practice inadequate overall but specifically the rating for providing a safe, effective and well led service was inadequate. As a result the practice was placed in to special measures for a period of six months from 4 February 2016. We carried out this further comprehensive inspection to ensure that sufficient improvement had been made in order for the practice to be taken out of special measures.

Why we carried out this inspection

On 17 September 2015 we had 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. That inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. At that inspection we found the practice inadequate overall but specifically the rating for providing a safe, effective and well led service was inadequate. As a result the practice was placed in to special measures for a period of six months from 4 February 2016. We carried out this further comprehensive inspection to evaluate whether sufficient improvement had been made in order for the practice to be taken out of special measures.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 July 2016. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being interacted with and talked with family members
- Reviewed samples of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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)

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

At our inspection in September 2015 we found that the practice did not have processes in place to prioritise safety, identify risks and improve patient safety such as a process to learn from significant events or complaints.

At our most recent inspection we found the practice had revised their significant event process and policy. There was now a comprehensive system in place. A log was kept of significant events, with each incident numbered, risk rated and details kept of review date, actions, when to be completed by and where and when learning outcomes had been discussed. Significant events were discussed at practice meetings and minutes of these were shared with all staff in order that those not able to attend the meeting were included in the learning.

The dispensary had 13 recorded significant events from September 2015 to the end of May 2016.

We looked at these events which had been reviewed at a two monthly significant event meeting.

There was a numbered system which made them easy to identify and corresponded to the significant event meeting minutes. However we found that in some of the significant events there was not enough detail recorded to enable a detailed action plan to be put in place and themes and trends to be identified. For example, there were two episodes where a prescription had been given to the wrong patient as they had the same name and three where a patient had been given the wrong prescription.

The incident recording system supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and we found that the practice had reported incidents through the National Reporting and Learning System (NRLS). The NRLS is a central database of patient safety incident reports which are analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

There was an effective system in place for dealing with safety alerts. There was a safety alerts policy in place which had been reviewed in June 2016. We saw evidence of alerts that had been actioned as necessary and where appropriate been discussed at practice meetings. For example, we looked at an alert which had been received at the end of June 2016 regarding electrical sockets and saw that the necessary action had been taken and this had been documented.

There was also a folder in the dispensary of alerts that had been passed to them and again a record was kept of actions taken and the alerts were signed to indicate who had reviewed them. We saw evidence in the dispensary of an alert recently received in relation to contraindications in a medicine used to treat many different types of infections caused by bacteria.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding. The GPs attended regular safeguarding meetings and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3 and nurses to level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones was trained for the role and had received a Disclosure and Barring Service (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). At the previous inspection we found that the chaperone policy was not specific to the practice and not dated. At this inspection we saw that the policy was dated May 2016 and was relevant to the practice, detailing those members of staff trained to chaperone.
- At the time of our inspection in September 2015 we found that in respect of infection control the practice policy was not clear and that full infection control audits

had not been undertaken. There had been no system for keeping COSHH safety data sheets up to date with some not having been updated since 2004. Sharps bins and external clinical waste bins were not being assembled or stored in line with national guidance and privacy curtains were out of date.

- However at our most recent inspection we found that the practice infection control policy had been reviewed and updated. There was an effective and comprehensive system in place for reviewing COSHH information, sharps bins were assembled correctly, external clinical waste bins were secure and there was now a system in place to ensure that privacy curtains were changed at appropriate intervals and had last been changed in March 2016.
- We also found that the practice maintained appropriate standards of cleanliness and hygiene and found the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who had carried out extended training and liaised with the local infection prevention teams to keep up to date with best practice. Staff had received up to date training. Quarterly infection control audits had been undertaken and we saw evidence that action was taken to address any improvements identified as a result.

At our inspection in September 2015 we found issues in the dispensary relating to the Standard Operating Procedures (SOP's), a lack of correlation between information supplied in respect of the Dispensing Services Quality Scheme (DSQS) and what we found during the inspection and no evidence that competence checks of dispensary staff had been carried out. SOP's should cover all aspects of work undertaken in the dispensary and consist of step-by-step information on how to execute a task.

At our latest inspection we found that the practice had reviewed and updated all the SOPs and they had a date for a future review. All staff involved in the procedures had signed a front sheet to say they had read and understood the SOP and agree to act in accordance with its requirements. They reflected good professional practice and detailed the procedures that were actually performed in the dispensary. However the SOPs still did not indicate the level of competency expected for each function performed by dispensers. No reference had been made to any dispensing procedures which had been amended. There was no written audit trail of amendments to SOPs.

We looked at the current DSQS information for 2015/16 completed by the prescribing lead. It reflected what we saw on the day of the inspection, other than a DRUM audit had not yet been completed by the prescribing lead. We saw evidence that DRUMs had taken place and the prescribing lead told us they would do a DRUM audit the following year.

At this inspection records showed that all members of staff involved in the dispensing process had received appropriate training. We saw evidence of records which demonstrated that their competence had been checked in March 2016.The records which were signed and dated showed that the dispensary staff were competent to perform the tasks and roles assigned to them in line with national guidance.

The practice dispenses medicines to over 53% of their population. They used a bar code scanner to improve accuracy and efficiency of the dispensing process. Staff described a process for ensuring second checks when dispensing certain medicines, for example, Controlled Drugs.

The dispensary accepted back unwanted medicines from patients. NHS England's Area Team made arrangements for a waste contractor to collect the medicines from the dispensary at regular intervals. We found that the dispensary had secure containers to keep the unwanted medicines in but there was no records kept of the medicines received by the practice.

The practice held a minimal stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the destruction of controlled drugs.

At our inspection in September 2015 we found that refrigerator temperature records had not always been recorded daily in line with national guidance to ensure they remained within specified limits. At this inspection we found that the dispensary had two pharmaceutical medicine refrigerators in place. Both had secondary thermometers and we saw records that the temperatures were being checked on a daily basis. All the medicines we

checked were within their expiry dates. However on the secondary thermometers the parameters for the min and maximum were not set in line with the practice policy which stated that they should be within 2 and 8 degrees. We spoke with the dispensary team who told us these would be reset.

The practice had a new policy and procedure for maintaining the vaccine cold chain. This was put in place in May 2016 and a copy was seen on the side of each medicine refrigerator. We checked medicines stored in the treatment room and the medicine refrigerators at the main surgery and found they were stored securely and were only accessible to authorised staff.

In September 2015 we saw that the dispensary door was being used by staff as a cut through to the kitchen area and reception and concluded that this could be a distraction to the dispensers. At this inspection we saw that the dispensary door through to the kitchen area and reception was closed. It had a poster in place to inform staff that it was not a cut through. We spoke with dispensary staff who told us that staff had reduced the amount of times it was used as a cut through and they were also mindful not to distract or interrupt a dispenser whilst they were in the process of dispensing medicines.

At this inspection we found that there was not an effective process in place for the signing of repeat prescriptions. Repeat prescriptions were not routinely signed by a GP prior to patients collecting medicines which fell outside current guidance. We spoke with a GP partner who immediately changed the process to ensure repeat prescriptions were signed before they were issued. After the inspection we received a revised repeat prescribing SOP and an assurance from the prescribing lead that all repeat prescriptions would be signed before the medicines were dispensed to the patient.

At our September 2015 inspection we found failings in relation to the monitoring of high risk drug

prescribing. Following that inspection the practice formulated a 'methotrexate prescribing

protocol.'They carried out an audit looking at all aspects of methotrexate prescribing but

particularly the blood monitoring needed to ensure safe prescribing. An initial data collection in October 2015 identified that 53% of patients had bloods taken in accordance with shared care

agreement guidelines. Following these findings, a new protocol and computer template for

patients prescribed methotrexate was developed. The effectiveness of these were evidenced by a

reaudit in January 2016 which showed that 100% of these patients had correctly linked blood

tests. This figure was still at 100% when reaudited in April 2016.

At our inspection in July 2016 we looked at the records of three patients on methotrexate and found that two had been monitored in line with guidance but the third had attended in May 2016 for a blood test for Methotrexate screening. Records showed that the sample had not been processed at the hospital as it was unlabelled. However the methotrexate was still prescribed. We raised this with the practice who raised a significant event in order to ensure that learning from the event was implemented so that methotrexate would not be prescribed without a satisfactory blood test. The patient had already been contacted for their next blood test prior to our inspection and following our visit the practice informed us the blood test had been satisfactory. The practice also told us that as they now had a process in place to reaudit methotrexate monitoring on a regular basis, the error would have been identified at that point.

Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed seven personnel files and found that on the whole, appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Since our last inspection a new dispensary manager had been appointed and we found there was not an updated contract of employment in their file. Also two staff files we viewed did not contain proof of identification.

Requires improvement

Are services safe?

Monitoring risks to patients

At our inspection in September 2015 we found that there were limited procedures in place for monitoring and managing risks to patient and staff safety. At this inspection we found there were now effective procedures in place for monitoring and managing risks to patient and staff safety. There was an up to date health and safety policy available and annual health and safety risk assessments had been undertaken. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Monthly water monitoring checks were carried out and the legionella policy had been updated in June 2016. The practice had an effective risk register in place which had been compiled in May 2016 and each risk was rated and mitigated.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

At our inspection in September 2015 we found there were limited arrangements in place to deal with emergencies. For example, not all staff were up to date with basic life support training, arrangements for checking emergency equipment were not effective and there was not a comprehensive business continuity plan in place to deal with emergencies.

At this inspection we found there were now appropriate arrangements in place to deal with emergencies. We looked at the emergency equipment at the main surgery. Staff had access to oxygen and a defibrillator with both adult and paediatric defibrillator pads to be used for cardiac emergencies. All staff had received annual basic life support training

.

We found that staff had completed monthly checks of the equipment. In September 2015 the practice had put in place a standard operating procedure (SOP) for the monthly check of emergency equipment.

At the main surgery emergency medicines were easily accessible to staff in a secure area of the practice and staff we spoke with knew of their location. All the medicines we checked were in date and fit for use.

There was now a comprehensive service continuity plan and risk assessment. This was in place for major incidents such as computer loss, power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments and

  audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2014/15 were 86% of the total number of points available. This was lower than the local and national average and also lower than the practice's previous year's results of 94.5%. However we looked at the current results for 2015/16 which had not yet been published and found that the practice performance had now improved greatly and achieved 98% of the total number of points available.

At our inspection in September 2015 we found that in areas such as diabetes and hypertension the figures were low compared to local and national figures for the percentage of patients with an appropriate blood pressure reading in the previous 12 months. The practice had already identified this as an area for improvement and following that inspection had formulated and implemented a 'hypertension improvement plan' and a 'hypertension protocol'. At our recent inspection, records we looked at demonstrated an improvement in target blood pressures of less than 150/90 from 59% in June 2015 to 79% in March 2016.

The practice had also identified that improvements needed to be made in the areas of asthma and Chronic Obstructive Pulmonary Disease (COPD). The QOF results for 2014/15 showed that 74.6% of patients with COPD had received a review. The practice had employed a specialist COPD nurse to attend the practice to carry out reviews on this cohort of patients. The review included a management plan for each patient. This action was reflected in the unpublished QOF results for 2015/16 which demonstrated an increase to 92% in this area. With regard to patients with asthma, the figures for 2014/15 reflected that 63.8% of patients had received an annual review which was below the CCG average of 74.5% and the national average of 75.3%. The figures for 2015/16 showed a great improvement with 80% of patients having received a review.

In 2014/15, the practice was also an outlier for the percentage of patients on the diabetes register who had a record of a foot examination, having achieved 71.5% compared to CCG and national average of 88.3%. Again we saw that this had improved enormously to 97% in the 2015/16 results.

The figures for 2014/15 also showed that the practice had higher than local and national average exception reporting in some of the above areas such as asthma and COPD. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. We discussed this with the practice and found that these figures had been reduced by improving the system for reviewing patients and introducing new templates for clinical staff to use. In other cases we saw that patients had been appropriately exception reported.

In September 2015 we found that there was not an effective system in place for carrying out full cycle clinical audits and no system or process in place to identify areas for quality improvement.

At this inspection we now found that the practice had an effective system in place for quality improvement, including clinical audit. They had formulated a comprehensive audit programme and six audits were planned between April and October 2016. We saw evidence of seven audits having been undertaken from April 2015 to March 2016. Three of these were completed full cycle audits and two had reaudit dates for the following year. Following our inspection in September 2015 the practice had carried out a hypertension audit in order to identify and devise a strategy to adequately detect and treat patients with above target blood pressure in line with current best practice. In

Good

Are services effective?

(for example, treatment is effective)

June 2015, 59% of patients with hypertension had blood pressure less than 150/90 mmHg and at the reaudit in March 2016 this had increased to 79%, which was above the national average of 72%. At the time of our inspection this had increased further to 81%.

We saw evidence of a dispensary audit in March 2016 in which a random sample of 10 patient records where checked in relation to new medicines following a discharge from hospital. It was found that 100% of patients had had their new medicines accurately transferred to the practice record system. The practice planned to reaudit this process in March 2017. The practice participated in local audits, national benchmarking and peer review.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring and facilitation and support for revalidating GPs. At our September 2015 inspection we found that not all staff had received an appraisal in the last 12 months. Since then a new system had been introduced to monitor appraisals and the appraisal policy updated in May 2016. We now found that all staff had received a recent appraisal. In respect of the dispensers appraisals which had taken place in February and March 2016 we found that although an appraisal had taken place there were no notes recorded of the discussions that had taken place. We spoke with the practice manager who told us they would put a system in place to ensure that all discussions were documented and signed.
- Staff received training that included: safeguarding, fire safety awareness, basic life support infection control, chaperoning, mental capacity act and information governance. Staff had access to and made use of e-learning training modules and in-house training. At our previous inspection some training for basic life support was out of date and there was no fire safety training. At this inspection we found an effective training matrix had been implemented and required training had been undertaken or was planned. All staff had now completed fire safety training, other than two members of staff who were due to complete this the following month. Staff within the dispensary had not received training updates relevant to the role of the dispenser and dispensary staff we spoke with felt that training updates relevant to their role would be beneficial.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. At our inspection in September 2015 we found that not all patient records we looked at reflected an appropriate care plan. At our inspection in July 2016 we saw that the relevant care plans were in place.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. At our previous inspection we had found that there was not a clear system in place for dealing with patients at highest risk of an unplanned admission to hospital. At this inspection we found that a

Good

Are services effective?

(for example, treatment is effective)

new system had been implemented with a lead GP taking responsibility for this area. We found that patients had been reviewed and followed up if an unplanned admission had occurred.

At our previous inspection we found that a member of the administration staff was responsible for using the scanning coding process on the practice's electronic records system. At this inspection we found that following a significant event relating to this process whereby the wrong information was saved in a patient's record, the member of staff had received further training and supervision. Since then there had been no further incidents reported. We saw that any coding or diagnoses were added to patient records by a GP and post was then scanned and saved to patient records by the administrator.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We did not see evidence that all clinical staff had completed training in this area.
  When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 83% and the national average of 82%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds were 97.9% and five year olds from 94% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 14 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a responsive service and staff were helpful, caring and treated them as individuals, with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey published in January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Good

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 80 patients as carers (1.2% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a letter of condolence. If appropriate a visit to the family would also be considered. Bereaved families were given 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

The practice reviewed the needs of its local population and the local Clinical Commissioning Group (CCG) told us the practice were well engaged and had worked with them to secure improvements to services where these were identified.

- The practice offered a daily open surgery from 8.30am until 10.00am which meant same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were longer appointments available for people with a learning disability.
- Urgent access appointments were available.
- There were disabled facilities at both surgeries.
- All patient services were on the ground floor for greater accessibility.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- A hearing loop and translation services were available.

Access to the service

The main surgery was open between 08.30am and 6.00pm Monday to Friday with an open surgery from 08.30am to 10.00am and pre booked nurse appointments between 08.30am and 12.30pm. Prebookable GP and nurse appointments were available between 2.00pm and 6.00pm. The branch surgery was open between 8.30am to 12.30pm from Monday to Friday. It also opened between 4.00pm to 6.00pm on Mondays. Between 8.00am and 8.30am and 6.00pm and 6.30pm Monday to Friday an emergency doctor is available.

The practice did not offer extended opening hours. The open surgery meant that In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them. Patients who completed comments cards responded extremely positively about the availability of a daily open surgery.

Results from the national GP patient survey published in January 2016 showed that patient's satisfaction with how they could access care and treatment was comparable or better than national averages.

- 78% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 99% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 89% patients described their experience of making an appointment as good compared to the national average of 73%.
- 69% of patients said they didn't normally have to wait too long to be compared to the national average of 58%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Information was gathered in advance to allow for an informed decision to be made on prioritisation according to clinical need. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

At our inspection in September 2015 we found the system in place for handling complaints and concerns needed improvement. Written response was not always given, themes or trends had not been identified and there was a lack of information available to guide patients on the process for raising a complaint.

At this inspection we found there was now an effective 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. In addition to a poster in the waiting room, advising patients how to raise a complaint, a patient complaint form and leaflet were available in reception and online.

The practice had received five complaints in the last 12 months. We looked at three of these and found they had been satisfactorily handled and responded to in a timely way. We saw evidence that complaints had been discussed at practice meetings and lessons were learnt from individual concerns and complaints. There was also an annual review of complaints in order to analysis trends.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- Following our inspection in September 2015, the practice had reviewed and reflected on their vision and strategy and how to involve the whole practice in the delivery of it. They responded positively to our findings at the last inspection and extensive improvements had been made.
- There had been changes in the leadership team and structure and many new systems and processes had been implemented. The practice now described their ethos as one of being 'Partners in Care' and staff knew and understood the values. It was evident that all staff were involved, enthusiastic and committed in delivering this.
- The practice had a strategy and supporting business plans which reflected their vision and values and were regularly discussed.

Governance arrangements

At our inspection in September 2015 we found that the practice had a limited governance framework in place to support the delivery of their strategy. There had been a lack of effective systems in place in order to monitor quality and make improvements, limited arrangements for identifying and managing risks and an unstructured approach to dealing with significant events.

At our most recent inspection we found that systems and processes had been fully reviewed and the practice now had an overarching governance framework which supported the delivery of their strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were now aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Dispensary policies and procedures had been reviewed and updated with the support of a consultant pharmacist and there was now a full time dispensary manager in place.
- There was a new protocol and system for reporting and learning from significant events and complaints, supported by the change in culture which had resulted in an increase in the number of incidents being reported by staff.

Leadership and culture

When we inspected in September 2015 we found there was a lack of leadership in some areas. Meetings were not always regular and some staff did not feel supported and felt there was not always an open culture within the practice.

At this inspection we found there had been a change of leadership and a clearer team structure with shared lead responsibilities. There had been an evident change in culture within the practice in order to encourage staff to speak up and report incidents or complaints in a no-blame environment. This was apparent from the records we viewed and staff told us there had been many changes and they now felt supported in all areas and welcomed the culture of openness and honesty.

The partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology

Are services well-led?

Good

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

- The practice kept written records of verbal interactions as well as written correspondence.
- Staff told us and records we viewed reflected, that the practice held regular team meetings. There was now weekly partners meetings, monthly clinical meetings and monthly multidisciplinary team meetings relating to safeguarding and palliative care. On reviewing the minutes of the clinical meetings we found that there was not a set agenda and they lacked detail in some areas.
- Staff said they felt respected, valued and supported and spoke positively about the changes that had been made since our last inspection. All staff were engaged and involved in discussions about how to run and develop the practice, and the partners encouraged members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through surveys and complaints received. There was now a patient participation group (PPG) which was in its formative stages having only had two meetings at the time of our inspection. The two members of the PPG we met with spoke positively about the future of the PPG and the support they had received from the practice.
- The practice had gathered feedback from staff through meetings, appraisals and discussion. Staff told us that due to the change in culture since our inspection in September 2015, they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was proactive and forward thinking and had enlisted external help in order to address in a timely way, the issues identified at our inspection in September 2015. This had included support from the Clinical Commissioning Group, the Royal College of General Practitioners and the Local Medical Committee as well as building relationships with other local practices.

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:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.