Purbeck Health Centre

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 Purbeck Health Centre on 18 February 2015. Overall the practice is rated as good.

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

It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- There was continuity of care, with a variety of appointments available, and a minor illness service. Urgent appointments were available the same day.
- The enhanced level of supervision, support and training for nursing staff enabled the practice to implement the minor illness service to ensure that the needs of patients using this service would be met by a skilled and competent nursing workforce.

Summary of findings

- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Implement a risk management process that enables the practice to anticipate, identify, assess and mitigate risks to the provision of its services arising from incidents or events, including health and safety risks, fire, risks from water-borne infections and loss of all or parts of its service.

In addition, the provider should:

- Complete the infection control assessment that was recently commenced and take action to address any shortfalls, including the assessment of risk of water-borne infections. Ensure that the assessment is reviewed in line with Department of Health guidance to assess whether any actions have been effective.
- Make arrangements to improve privacy for patients speaking with staff at the reception desk.
- Evaluate the recently implemented nurse-led minor illness service and the realigned appointment system, with a focus on patient feedback, to consider whether any extended opening hours are required to meet the needs of this population.
- Update the information available to patients about making a complaint.
- Set out a clear, documented long-term strategy for the practice with objectives against which improvements can be planned and progress measured.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as 'requires improvement' for providing safe services as there are areas where improvements need to be made.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. The practice was also diligent in the way they reacted to and learned from significant events and safety incidents. The practice was clean and hygienic, followed infection control guidance and was in the process of carrying out its first infection control audit in three years. There were systems in place to protect children and vulnerable adults from potential abuse. There was sufficient staff on duty to ensure the service was safe. However, there was no process for anticipating, identifying or managing any risks to the service and no formal means of recording such risk. This included a fire safety risk assessment, a water-borne infections risk assessment and a continuity plan to enable the practice to maintain its service following a major incident of event. We have required the provider to make improvements.

Are services effective?

Good

The practice is rated as 'good' for providing effective services.

Nationally collected data showed patient outcomes were similar to expected for the locality with two exceptions that the practice had been addressing. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation and standards. This included assessing capacity, promoting good health and preventing ill-health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Patients with particular needs, such as those receiving end-of-life care and those who were most at risk of hospital admissions had individual care plans. The practice used well-established information management systems and worked well with other providers.

Nurses at the practice were skilled in a number of areas, including long term conditions and minor illnesses. The practice had invested significant time and funding into ensuring they received good quality external training, regular, scheduled clinical supervision and that they had protected time in which to provide peer support to each other.

Summary of findings

Are services caring?

Good

The practice is rated as 'good' for providing caring services.

Nationally collected data showed that patients' satisfaction rates were historically lower than others for several aspects of care and similar to expected for other aspects. However, more recent data collected as part of the 'Friends and Families' test showed that the practice was caring. Patients said they were treated with compassion, dignity and respect and this was reflected in comment cards which we had left for patients to complete. Patients said they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand. Staff treated patients with kindness and respect, and maintained their dignity. Patients and those close to them were supported to cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as 'good' for providing responsive services.

It reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. Historically, patients said they had found it difficult to make an appointment with the GP due to the appointment system that was in operation. However, the appointment system had recently been realigned and the practice had introduced a minor illness service to enable more efficient patient access to the right level of care. As this had been operative for a short period of time it had not been evaluated to see if it had been effective. A variety of appointments were available with some bookable in advance and others available on the same day for emergencies, although there were no extended opening times. The practice had appropriate facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints took place.

Are services well-led?

Good

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

It had a shared vision among staff of putting patients' needs first and worked to a patient charter that all staff were familiar with. Staff worked well together and presented as a happy, cohesive team. The practice had taken robust and significant steps to respond to adverse comments about appointment availability by implementing a new resourcing model and realigning their appointment system. There was a clear leadership structure and staff felt supported by management. The practice had clear and up-to-date policies, procedures and protocols to govern activity and held regular governance meetings. There were systems in place to monitor and

Summary of findings

improve quality including the analysis of significant events and clinical audits. The practice proactively sought feedback from staff and patients, which it acted on although there was no patient participation group. Staff were well supported and valued and the nursing team received effective clinical supervision. There were processes in place to manage poor performance.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as 'good' for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people and had a range of enhanced services, for example, in dementia and end-of-life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice also ran fortnightly nurse led outreach sessions and monthly GP outreach sessions at a nearby sheltered housing scheme for older people who lived there.

People with long term conditions

Good

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

Nursing staff had lead roles in chronic disease management and were trained to an advanced level. Patients with diabetes had individual diabetic care plans. Patients at risk of hospital admission were identified as a priority and had an individualised care plans. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances. Immunisation rates were relatively high for all standard childhood immunisations. Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Staff knew how to recognise and respond to children at risk. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked jointly with midwives, health visitors and school nurses. The practice ran minor illness clinics which ensured families with children who were poorly could be seen when they needed to be.

Summary of findings

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 had changed its appointment system and introduced minor illness clinics to ensure people could be seen when they needed to be. The practice and sent out text reminders for all patients who had booked appointments in advance. However, the practice did not offer extended hours for those who worked during practice opening hours. The practice carried out adult health checks for patients aged between 45 and 70 who did not otherwise have an existing medical condition. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as 'good' for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and data showed that all of these patients had received a follow-up. It offered longer appointments, and appointments out of scheduled times for people with a learning disability or for those with complex needs. People who required it could access the service as registered temporary patients.

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, such as those for substance misuse those for patients who were caring for others. 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).

Summary of findings

83% of patients identified as experiencing poor mental health had received an annual physical health check which was similar to expected. 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. It provided advice to patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND and other local groups. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with two patients on the day of our inspection, reviewed 13 comment cards that had been collected from patients in advance of our visit and looked at data from the 2015 National Patient Survey. We also considered views expressed in the practice's 'Friends and Family' test survey and looked at reviews posted on NHS Choices web-site (nine reviews in the year prior to our inspection).

There was some disparity between historical views of patients shown in nationally collected data and the more recent views expressed by patients during our inspection, reported on comment cards and data collected by the practice. The historical data showing largely negative experiences or adverse views of patients pre-dated the implementation of a new appointment system that incorporated a minor illness clinic. In this respect, some of the historical views of patients were at odds were other, more recent evidence we found.

Data from the National Patient Survey up to January 2015 showed that 55% or patients found the practice to be 'good' or 'very good' and 47% said they would recommend the practice. These satisfaction rates were significantly lower than the average for the clinical commissioning group (CCG) area. However, more recent data from the 'Friends and Family' questionnaires left by patients during February 2015 showed that 94% of patients stated they would recommend the practice. This was supported by the views of patients we spoke with and most views shown on comment cards.

Patients reported that they were treated with kindness and respect and that they were involved in decisions about their care and treatment. Data from the 2015 National Patient Survey showed satisfaction rates with the nursing team was similar to expected whilst those relating to the GPs was lower. Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement and that they felt in control and this was supported by views expressed in comment cards. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions.

Patients we spoke with on the day of our visit said they were satisfied that the practice was meeting their needs. Three of the 15 comment cards left by people visiting the practice prior to our visit expressed a view on the practice's responsiveness to their needs. All three of these views were positive.

The 2015 National Patient Survey results showed that patient satisfaction with the practice's opening hours was among the lower 25% in the country as was patients' satisfaction with their experience of making an appointment. Five of the nine reviews on the NHS Choices web-site from 2014 commented adversely about appointment availability. However, this survey and all of these comments related to visits that pre-dated the introduction of the minor illness service which had not been evaluated.

Only one of the patients who left comment cards for us reported not being able to get an appointment and both patients we spoke with said they had never had any problems getting an appointment.

Areas for improvement

Action the service MUST take to improve

Implement a risk management process that enables the practice to anticipate, identify, assess and mitigate risks to the provision of its services arising from incidents or events, including health and safety risks, fire, risks from water-borne infections and loss of all or parts of its service.

Action the service SHOULD take to improve

Complete the infection control assessment that was recently commenced and take action to address any shortfalls, including the assessment of risk of water-borne infections. Ensure that the assessment is reviewed in line with Department of Health guidance to assess whether any actions have been effective.

Summary of findings

Make arrangements to improve privacy for patients speaking with staff at the reception desk.

Evaluate the recently implemented nurse-led minor illness service and the realigned appointment system, with a focus on patient feedback, to consider whether any extended opening hours are required to meet the needs of this population.

Update the information available to patients about making a complaint.

Set out a clear, documented long-term strategy for the practice with objectives against which improvements can be planned and progress measured.

Purbeck Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector who was supported by a GP specialist adviser.

Background to Purbeck Health Centre

Purbeck Health Centre is a community general practice that provides primary medical care for just over 6,800 patients who live in a moderately populated area in the town of Milton Keynes. According to Public Health England, the patient population has a slightly higher than average percentage of patients aged under 39 years as compared with the rest of England. There is a less than average percentage of patients aged over 65.

The practice is in an area considered to be between the lower 40% and 50% more economically deprived areas in England.

Purbeck Health Centre has three GPs, two of whom are male and partners in the practice; one female GP is a locum GP who works exclusively at this practice. There are three practice nurses who are advanced practitioners and who can prescribe medicines, and two healthcare assistants. The nursing team run a variety of long term condition clinics and also a minor illness service. The health visiting team and school nurse team are also based in the same building and the community midwife team run occasional clinics from the practice.

There is a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6.30pm, Monday to Friday. Outside of these hours, primary medical services are accessed through the NHS 111 service.

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 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.

This provider had not been inspected before and that was why we included them in this round of inspections in the Milton Keynes Clinical Commissioning Group (CCG) area.

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

We conduct our inspections of primary medical services, such as Purbeck Health Centre, by examining a range of

Detailed findings

information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 18 February 2014. During our visit we spoke with two of the GPs, the practice manager, members of the nursing team and administration staff.

We spoke with two patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 15 CQC comment cards completed by patients using the service prior to the day of our visit day where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Requires improvement

Are services safe?

Our findings

Safe Track Record

We found that Purbeck Health Centre had an open and transparent culture amongst its staff about keeping people safe. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts were cascaded to all staff by the practice manager and we saw that the nursing team had monthly meetings where they discussed those alerts that affected their work. The practice also used comments and complaints received from patients as well the analysis of significant events.

This was supported by clear procedures for escalating incidents, near misses and allegations of abuse that were used by all staff. For example, there were significant event forms that staff could access easily and these were used to escalate concerns for discussion at the practice partners' meetings. We reviewed significant event logs as far back as 2007 which showed that the practice had a safe track record because it was consistent in its approach over time and took action to address safety issues.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and learning from significant events, incidents and accidents; a process known as significant event analysis (SEA). All staff were empowered to report incidents and events and could determine whether an event was deemed to be significant and thus required further investigation.

We reviewed the notes of the monthly practice partners' meetings and saw that safety issues and significant events were discussed as a standing agenda item. We also reviewed complaints records, comments received and records of incidents. These records showed that incidents, feedback and concerns were discussed with the object of learning from them. In most cases we reviewed we saw that an action plan had been drawn up to ensure that any shortfalls identified were rectified. Outcomes and any learning arising from these incidents were communicated to staff through monthly protected learning time (PLT) sessions or through notifications on the practice IT system if more urgent.

We saw a number of examples where this process had been consistently applied and one particular case, a prescribing issue, where a comprehensive root cause analysis had been carried out. In that instance, a number of clear action points had been identified with the practice manager designated as the person responsible for implementing changes and communicating these to staff. We saw that the processes relating to communicating with patients within the urgent prescription protocol were revised. Staff were informed of the revisions to the protocol, as well as the reasons for the changes, by way of a memorandum and through the next PLT session.

This was also the case for staff who were not directly employed by the practice but who had a role in treating the practice's patients. For example, we reviewed a SEA record that related to an antibiotic prescribing error, which resulted in learning for the community nursing team as well as the practice.

Reliable safety systems and processes including safeguarding

The practice had policies and systems in place to manage and review risks to vulnerable children, young people and vulnerable adults. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their role. For example, the GPs and the nurses had been trained to the appropriate level described in the joint guidance issued by their respective Royal Colleges.

Effective safeguarding policies and procedures were in place, up to date and were fully understood and consistently implemented by staff. There were regular, ad hoc meetings with the health visiting service to manage and review risks to vulnerable children. The practice IT system alerted staff to children who were the subject of a child protection plan or who were looked after by the local authority when they arrived for appointments.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children and we tested this knowledge through the use of hypothetical scenarios. They were also aware of their responsibilities about documenting safeguarding concerns and how to contact the relevant agencies during office hours and out-of-hours. We saw that information about the local authority's safeguarding process was readily available.

Patients' records were held securely and electronically; staff had received appropriate training in information governance and were familiar with the practice's policy for protecting patients' confidential information.

Requires improvement

Are services safe?

A poster advertising the availability of a chaperone was visible to patients on the waiting room noticeboard and a policy was available for staff to refer to. Chaperone training had been undertaken by nursing staff and healthcare assistants who carried out this role and both female patients we spoke with confirmed that they had been offered this service. A chaperone is someone who is present during an intimate examination whose role is to ensure that patients are safe.

Medicines management

We found that there were clear procedures for the management of medicines that minimised the potential for error. For example, we found evidence that the nursing team were working with patient group directions (PGDs) that were up-to-date, signed and held on the practice intranet and in hard copy form. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before they present for treatment, such as vaccinations or family planning medicines.

The three nursing staff were all qualified to an advanced level which meant that they could independently prescribe medicines. The practice encouraged and supported them to attend additional training to ensure they received regular updates in specific clinical areas for which they were prescribing.

We saw that the cold chain was maintained for the reception, transfer and storage of temperature sensitive medicines, such as the flu vaccine. There was a system for monitoring the fridge temperatures daily so that the practice was assured the vaccines remained viable and safe to use.

All other medicines, including those used in a medical emergency, were stored appropriately and were checked by the designated lead nurse who was in charge of medicines. We saw signed and dated entries in a log book which showed that there were also arrangements to check the medicines when the nurse was on leave.

There was a repeat prescription protocol that met national guidance and all three administrative staff who processed repeat prescriptions had been trained in its operation. Repeat prescriptions were received directly at the practice, by post or through the online system. All requests were managed through the practice computer system before they were handed to a GP for signing. This allowed an effective audit trail to be kept. The system also enabled staff to be alerted when a patient's medicines were due to be reviewed or if a patient had not requested a repeat prescription by the due date.

All high risk medicines were the subject of alerts on the computer system and requests were automatically referred straight to the GP for review. The practice did not stock controlled drugs.

Cleanliness and infection control

The practice was part of a multi-use premises maintained the Central and North West London NHS Foundation Trust (the community health trust). The building was cleaned by contractors deployed by the community health trust according to a schedule of daily, weekly and twice weekly cleaning tasks. There were no formal monitoring records or check sheets in place to enable the management of the practice to check the effectiveness of the cleaning schedules. However, we saw that the practice had recently had concerns about the standard of the cleaning arising from observations of the staff. As a result, the practice had had dialogue with the community health trust's contractors to resolve this issue satisfactorily.

Clinical areas and surfaces in treatment rooms were cleaned by the nurses who used the room on an on-going basis during the day. On the day of our inspection we saw that the practice was visibly clean and tidy. We saw that there were soap, hand gel and towel dispensers in place as recommended by the Department of Health (DH) guidance along with notices advising staff about hand-washing.

There were different types of waste bin for general and biological waste and appropriately marked and dated containers for disposing of used sharp instruments. All clinical waste was collected weekly by the community health trust's contractors.

There was an infection control policy that had been updated in the week just prior to our inspection and one of the nurse practitioners had recently been designated as a lead for infection control. The nurse had received additional advanced level training in infection prevention and control in the month before our inspection and was a point of reference for all staff. The practice acknowledged that they had not carried out an infection control self-assessment as recommended by the DH guidance within the last three years but we saw that this process had just been started by the newly designated lead nurse.

Requires improvement

Are services safe?

We were told that, as the practice occupied premises controlled by another organisation, it did not have its own policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). However we also saw that it had not carried out its own risk assessment in relation to legionella and so could not be assured about the safety of the water supply in the area of the building occupied by the practice.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. For example, the nurse told us that they had enough equipment to carry out their role effectively such as a spirometer (used in lung function tests). We saw evidence that this, and other equipment such as an electro cardiograph (ECG) machine and blood pressure monitors were calibrated by an external company to ensure they were operating accurately and safely. We saw that all equipment was tested and maintained regularly and we viewed equipment maintenance logs and other records that confirmed this. All portable electrical equipment displayed stickers indicating that the last testing date was June 2014.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to people being employed to ensure they were safe. We saw proof of identification, qualifications, registration with the appropriate clinical professional body and, where applicable, criminal records checks through the Disclosure and Barring Service (DBS). All medical and nursing staff had checked through the DBS as well as all staff who had direct contact with patients and those who performed the role of chaperone.

The practice reported to us that it had experienced a depletion of medical and nursing staff since 2008 due to retirements and career changes and that recruiting clinicians had been problematic. The current establishment of two full-time partners and one regular, almost permanent locum GP had been in place since 2014. The practice had carried out work to establish how it would provide a safe service for its 6,800 patients with comparatively fewer GPs than other practices in its area. As a result, the practice had provided additional nurse training and had recruited additional staff to implement a revised staffing model that involved three advanced, prescribing nurse practitioners. This enabled the practice to provide 24.5 GP sessions, 20.5 nurse sessions and six healthcare assistant sessions each week, which included nurse-led minor illness and chronic disease clinics. This had led to a reduction in the frequency that locum GPs were required although the practice acknowledged that occasionally this would still be necessary in periods of absence.

Staff rotas were set in advance and the staffing requirement was managed through the practice's computer system, which identified when staff were available and how many appointments were booked for each GP and nurse. Staffing was monitored frequently by the practice manager through this system so that the staffing levels could be adjusted or increased to meet higher demand. In this way, planned absences such as staff leave and unexpected absence due to sickness were managed and cover arranged as appropriate.

Non clinical staff told us that they always covered for each other during leave or sickness absence and they had been trained to carry out each other's roles.

Monitoring safety and responding to risk

We saw that the practice had procedures in place to deal with potential medical emergencies. All staff had received annual training in basic life support and in the use of two automated external defibrillators (AED). The AEDs and two emergency oxygen cylinders were readily available and checked daily.

The practice carried a small stock of medicines for use in the event of a medical emergency such as a heart attack or severe shock due to an allergic reaction. These medicines were checked monthly to ensure they were within their expiry dates.

We found that staff at all levels were empowered to raise immediate concerns they might have about any particular patient with a clinician, even if they were unsure about what they had identified. Staff we spoke with said they were confident in recognising patients who might arrive at the practice with acute clinical needs requiring a clinician's input as a priority. We learned of a number of instances when this had occurred as well as an occasion when the AED had been used.

Requires improvement

Are services safe?

The practice had a 'duty doctor' system. The GP that was designated as duty doctor on any given day was responsible for responding to any risks to individual patients. For example, the duty GP carried a dedicated mobile telephone with the number being accessible by those patients that were most at risk of hospital admissions.

Arrangements to deal with emergencies and major incidents

The practice did not have arrangements in place to manage emergencies or major incidents that affected its capacity to provide a service. The practice did not have a business continuity plan that described how to deal with incidents that might adversely affect the daily operation of the practice. Staff told us that the clinical commissioning group (CCG) and other local practices would be contacted to assist with temporarily relocating patients and managing appointments. However, there was no formalised plan to describe how this would take place, who would be contacted and whether or not neighbouring practices had agreed to such an undertaking.

We also found that there were no risk assessments available that related to the health safety of the premises, patients and staff. For example, there was no fire risk assessment available and no legionella assessment as reported above. There were also no formal risk logs in use to capture any emerging risks to patients and staff. We acknowledge that the premises in which the practice was located were managed by the community health trust. However, the absence of any documented risk assessments or business continuity plan showed that the practice would be unprepared to anticipate, identify or manage any incident or event that could cause a loss of all or parts of the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. This included the use of best practice and clinical guidance described by the National Institute for Health and Care Excellence (NICE). It also included local guidance emanating from the local clinical commissioning group (CCG) such as child health surveillance guidance and prescribing guidelines. We saw that guidance was disseminated to all clinical staff at the weekly clinical meetings between the GPs and the nurses.

We learned that the GPs had particular areas of special interest or expertise, such as diabetes, respiratory conditions, dementia, gynaecology, minor surgery and prescribing. As a result, the need for referrals onwards to other services was reduced as patients could receive specialist treatment 'in-house'. We also saw that the nurses were trained to support recently diagnosed diabetic patients with the start-up of their insulin treatment. Nonetheless, whenever referrals to other services were required these were discussed as part of a referral management protocol that involved the practice manager and one of the GPs to ensure consistency of approach.

We noted that the practice had used a risk identification tool to identify patients that were most at risk of repeated hospital admissions and were managing their care through individually tailored, proactive care plans. Additionally, we reviewed the records of the three-monthly multi-disciplinary (MDT) meetings held between the GPs, nurses, the community nursing team and palliative care nurses. These records showed the practice had an active programme of monitoring the care and treatment of those patients who were receiving end-of-life care and those patients who were receiving care for complex conditions.

The practice had a diverse work force and we saw no evidence of discrimination in decision making about care and treatment decisions.

Management, monitoring and improving outcomes for people

We saw that the weekly clinical meeting played a key role in monitoring and improving outcomes for patients. For example, we saw the notes of a meeting in November 2014 at which all clinical staff were present when the practice's approach to the prescribing of a particular type of opioid medicine was discussed at length. The outcome of this meeting was a commitment to a revised policy on prescribing to ensure patients who were not part of a long-term pain management plan had this medicine reduced or replaced with a different kind of medicine. This ensured that all prescribers at the practice followed a consistent approach to patients who had been taking this medicine.

The practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. We noted that national data, including data obtained from the QOF, showed that the practice was performing in line with expected standards and rates for identifying, registering, treating and prescribing for most conditions.

To support this, the practice had a culture of monitoring performance through clinical audits. A clinical audit is a performance assessment process that identifies the need for improvement or change, then measures performance once changes have been implemented in order to assess their effectiveness. One example of this was an audit of infection rates after minor surgery. We saw that the initial infection rate after minor surgery was measured using data from the practice system. The practice introduced single use instruments after the initial review as opposed to re-used sterilised instruments. The subsequent infection rate was measured again six months later and was found to have halved showing that the change introduced had been effective.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area; for example in their referral rates.

Effective staffing

We looked at records and spoke with staff and found that for both clinical and non-clinical staff were appropriately trained and supported to carry out their roles effectively.

Good

Are services effective?

(for example, treatment is effective)

Each of the GPs had one or more areas of clinical expertise which they were leading on for the practice and this enhanced the service they were able to provide to their patient population.

New staff received an induction programme that introduced them to their role although the low turn-over of staff meant that this was used infrequently. We saw that there was a range of non-clinical training for staff that was specific to their role such as on-the-job training specific for reception staff that was managed through a competency checklist. Staff had been trained in different roles; whilst some staff had designated duties, such as prescriptions for instance, we saw that staff could interchange most administrative roles and this helped the practice to cover for leave or sickness absence.

There was a system in place to ensure staff received training that the practice deemed to be mandatory, such as basic life support training, health and safety and safeguarding. Some training was delivered to staff through monthly protected learning time (PLT) sessions.

All clinical staff undertook continuing professional development in order to fulfil the revalidation requirements of their professional bodies such as the General Medical Council and the Nursing and Midwifery Council. In addition, the practice had funded training courses for the nursing staff to ensure they were skilled enough to provide an advanced level of service. Such training included diabetes, respiratory conditions, minor illnesses and prescribing. The nurses also received weekly, clinical supervision sessions with the GPs on a topic of their choice as well as being able to raise any issues for discussion on an ad hoc basis. This time was protected and set aside for this purpose. During these weekly sessions they were enabled to provide peer support to each other by reflecting on and discussing their own practice and new guidance. The nurses told us that this was a very supportive and flexible system that they valued greatly. The enhanced level of supervision, support and training enabled the practice to implement the minor illness service and to ensure that the needs of patients using this service would be met by a skilled and competent nursing workforce.

All staff also received an annual appraisal although at the time of our inspection this year's appraisals had not been completed. The practice manager was in the process of delegating authority for some lead tasks, such as appraisals, to other key members of staff to ensure that staff did not miss out on this level of support. Nonetheless, staff we spoke with told us they felt supported and that the management team were approachable at any time if they had any issues about their work.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the community nursing team, health visitors, the emergency department of the local hospital and the local ambulance service. The evolving needs of every patient receiving end-of-life care were discussed at three-monthly multi-disciplinary team (MDT) meetings involving the practice nursing team, the community nursing team and palliative care nurses. Such patients' care plans were left with the patients so that other health professionals were who visited were fully informed of their needs. As patients neared the very end of life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service and the out-of-hours service to ensure that specific wishes about their death could be met.

All records of contact that patients had with other providers, such as contacts with the NHS 111 service and out-of-hours providers were mainly received electronically, but occasionally by fax or post on a daily basis. There was a clear process for handling the records of such contacts which were all sent to one of the GPs for clinical review, usually the last GP to see the patient. This ensured that the practice retained clinical oversight of their patients' encounters with other health services and could coordinate any further or follow-up action indicated by them.

As reported above, whenever referrals to other services were required these were discussed as part of a referral management protocol that involved the practice manager and one of the GPs to ensure consistency of approach.

Information sharing

The practice used an established electronic patient records management system to provide staff with sufficient information about patients. All staff were trained to use this system. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk. The

Good

Are services effective?

(for example, treatment is effective)

practice system was also the gateway to an electronic referral management system which facilitated the referrals on to other services such as the hospital outpatients. This system was readily available and accessible to all staff.

The system also enabled correspondence from other health care providers, such discharge letters or blood and other test results, to be held electronically to reduce the need of paper held records. The system also allowed for hard copy correspondence to be 'scanned in' and held on patients' records although those occasions were infrequent.

The practice had begun to use the electronic Summary Care Record system. The Summary Care Records provide key, clinical information about individual patients to healthcare professionals to enable faster access in an emergency or out of normal hours. For patients who were referred directly to hospital by the practice, a handwritten referral letter was provided for them to take with them to hospital although the practice had plans to introduce a printed summary for this purpose.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation and guidance. This consent was either implied, in respect of most consultations and assessments or was explicitly documented in the case of minor surgical procedures. For such procedures the practice used template forms that were taken from the practice computer system. These forms explained the procedure or process in detail to enable patients to fully understand their treatment and to provide written, signed consent.

Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. We saw that the provisions of the Mental Capacity Act 2005 (MCA) were used appropriately and that assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or patients who lived with dementia. However we noted that there was no recent staff training in the MCA although relevant policies and guidance to support staff was available on the practice's intranet.

Health Promotion and Ill-Health Prevention

We found that patients were supported to live healthier lives in a variety of ways. The practice was in the process of providing adult health checks to patients over the age of 40 who were not otherwise receiving treatment. This was in accordance with the NHS' current programme to improve the health of people in this age group.

The practice had also been providing flu vaccination clinics for older patients and for those who were most at risk, as well as the shingles vaccination to patients over the age of 75. Nationally collected data from the previous financial year showed that the practice had achieved a take-up rate that was similar to expected for flu vaccinations in adults who met the eligibility criteria. We noted that the practice had achieved between 95% and 98% take-up rate for childhood immunisations. This figure was higher than the average for the rest of the CCG area.

The practice held registers of patients with long term conditions such as diabetes, respiratory, cardiac and kidney conditions. The practice used the registers to manage an active recall programme for regular monitoring of the on-going health of these patients. This was also the case for patients with learning disabilities. Nationally collected data also showed that the practice had achieved a take-up rate that was similar to expected showing that the recall system was effective.

Screening for cervical cancer was also provided by the practice according to current guidelines although the take-up rate was lower than the national average. The national data also showed that the practice was similar to expected for most aspects of health monitoring for patients with mental ill-health. However, the proportion of patients with mental ill-health who had an agreed care plan was lower than expected.

The practice was actively monitoring their data on the QOF, so they were aware of these shortfalls. The practice manager explained that the new resourcing model that had been brought about in 2014 due to the depletion of medical and nursing staff had provided opportunities for the practice to be more proactive in addressing this. The

Good

Are services effective?

(for example, treatment is effective)

new model, comprising three GPs and three advanced nurse practitioners, had enabled them to focus on proactively targeting patients who did not attend for their appointments, to improve the level of health education provided to patients during consultations and to provide care planning where this was required as part of the service they offered. We found, for example, that there was a culture amongst the GPs and the nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing; for example, by offering chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. We learned of a specific example where a referral for a patient to a tissue viability nurse was used as an opportunity to carry our further health screening resulting in the practice being able to support the patient with controlling their diabetes.

Staff receiving incoming telephone calls were able to review the status of patients' health checks on the practice IT system and offer appointments accordingly. We saw this taking place during our inspection.

We saw that the practice provided a range of information about healthy living. This included leaflets and posters about healthy diet and smoking cessation. We noted that the practice web-site had an informative section with links to other organisations or to information about long-term conditions, family health and minor illnesses. This was supported by a self-test area in the waiting room containing a blood pressure monitor and scales. Patients could test their own blood pressure using this device and receive a print-out that they would take to reception to arrange a follow-up if necessary.

Patients who required extra support were identified and care was tailored to meet their needs, such as those patients most at risk of attending hospital accident and emergency department and patients with complex needs. As reported above, we also saw that patients who were receiving end-of-life care were discussed at three-monthly MDT meetings where the effectiveness of their individualised care plans was considered.

The practice had a carer's register which ensured that people who were looking after others were identified, offered the opportunity for additional support and referred onwards to other services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with two patients on the day of our inspection, reviewed 13 comment cards that had been collected from patients in advance of our visit and looked at data from the 2015 National Patient Survey. We also considered views expressed in the practice's 'Friends and Family' test survey, looked at reviews posted on NHS Choices web-site (nine reviews in the year prior to our inspection) and carried out observations throughout our inspection.

Patients' views of the practice were inconsistent. Data from the National Patient Survey up to January 2015 showed that 55% or patients found the practice to be 'good' or 'very good' and 47% said they would recommend the practice. These satisfaction rates were significantly lower than the average for the clinical commissioning group (CCG) area. However, data from the 'Friends and Family' questionnaires left by patients during February 2015 showed that 94% of 51 patients stated they would recommend the practice.

Five of the older reviews on the NHS Choices web-site reported that reception staff were rude or inattentive whilst one of the reviews stated that the GPs were also rude. The National Patient Survey up to January 2015 showed that 65% of patients thought their GP was good at treating them with care and concern, lower than the average satisfaction rate for the CCG. This figure rose to 77% in respect of patients' views about the care and concern shown by the nurses and this was similar to the rest of the CCG. However, only one of the comment cards left by patients in the weeks leading up to our inspection reported adverse comments about staff attitudes. All of those that expressed a view about dignity and respect reported that their GP and the nurses were courteous, considerate and compassionate. The patients we spoke with on the day of our inspection told us that they were treated with kindness, respect and dignity by all the staff at the practice.

Patients also told us that all the reception staff were polite and had a pleasant manner about them. This was borne out during our observations in the reception and administration areas when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk.

In addition to asking whether patients would recommend the practice, the 'Friends and Family' questionnaires also asked patients to comment on their overall care and state anything that might have been done better. All but one of the 15 comments we reviewed were positive with the remaining adverse comment being unrelated to respect and dignity.

We were told by the practice manager that many of the historical adverse comments about staff attitudes expressed through NHS Choices reviews had been as a result of frustrations around the practice's use of the telephone triage system in place before the latter part of 2014. This system had required all patients seeking on-the-day appointments to be spoken to over the telephone by a GP before determining whether the patient needed to be seen in person. Our examination of the nine comments received in the year before our inspection showed that six were related to staff attitudes to patients seeking appointments. We noted that there had been no such complaints about staff attitudes since the practice had revised its appointments system and implemented the minor illness appointments. In any event, we saw that the practice had addressed the attitudes of staff in a team meeting in March 2014.

We saw that there was only sufficient room at the reception desk for one patient at a time to be spoken to privately. However, there was no clear line, or point behind which patients could wait and no notice or sign to advise patients to wait to be called forward to be seen. During a short observation period in the reception area we noted that, on two occasions one person was being spoken to by the receptionists whilst another patient waited alongside for their turn to be seen. Reception staff told us that there was no other room or area that patients could be taken to if they wished to speak at reception in private. They said they tried to be discreet in the number of questions they asked patients at the desk in order to preserve privacy. Our observations confirmed that conversations were held in low tones.

There was a laminated notice that set out a 'dignity code'; a statement about what patients could expect in order to preserve their dignity. Staff we spoke with demonstrated they understood this code and told us that they always treated patients respectfully and with care and concern.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an

intimate examination is taking place to ensure that patients' rights to privacy are protected. One of the nurses explained the steps they took to ensure patients' dignity was preserved before, during and after an intimate examination. Both female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male GP.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey 2015 showed that, on average, 74% of patients felt the GP was good at giving them enough time, good at listening to them and good at explaining test results to them. The survey showed that 62% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were lower than the average for England in general but similar to more than half of the other GPs in the CCG area. The corresponding figures for the nursing staff were similar to both the England and CCG average with 78% reporting that the nurses gave them enough time, listened to them and explained test results, whilst 72% felt the nurses involved them in care decisions.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement and that they felt in control. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Four of the 15 comment cards we reviewed contained comments about whether patients felt listened to; three of these were positive whilst one patient commented that they felt they were not listened to. In the treatment rooms we saw a number of devices and visual displays that were used to provide explanations to patients about medical conditions or their diagnoses. One of the nurses explained how they used these to explain to patients what their treatment options were and to enable them to choose what was right for them.

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital services by the use of the practice's referral management system.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment.

Patient / carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, staff we spoke with told us they were made aware of the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Furthermore, relatives of patients who had died were called by the practice in order to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services. The practice also referred patients to a cognitive behavioural therapy service known as Improving Access to Psychological Therapies (IAPT). The IAPT service was located in the same building as the practice and IAPT staff we spoke with said they would often receive direct referrals from the practice.

We also noted that patients with long terms conditions were referred to external support groups such as a local group for patients with lung conditions and a local branch of Age UK. The practice actively took steps to identify patients who were carers, particularly younger carers. This group of patients were provided with information about local services providing practical and emotional support and referrals to these services were actively managed by the practice.

The care plans of people receiving end-of-life care and of those patients who were most at risk of unscheduled hospital admissions were discussed at multi-disciplinary team meetings. This ensured that the practice could regularly and actively monitor the evolving support needs of these groups of patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was responsive to the needs of its patient population and tailored its services to meet those needs. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice provided outreach primary medical services to a sheltered housing scheme in the nearby area of New Bradwell. The practice provided a monthly GP clinic and a fortnightly nurse led clinic from that location.

The practice had monitored its doctor consultation rate and its rates for patients who did not attend appointments (DNA). The practice had noted that the DNA rate had increased due to changes in the appointment system (reported below) and so had introduced a text messaging system whereby every patient that had booked in advance received a text message reminder to ensure that they remembered to attend or to cancel. This initiative had only recently been introduced and so its impact on DNA rates had not yet been evaluated.

Over the course of 2014, the practice had responded to persistent feedback from patients about poor appointment availability and had modified the way they provided their service. In addition, nationally collected data showed that this practice had a smaller proportion of patients with long standing health conditions when compared with the rest of the clinical commissioning group (CCG) area, and a greater proportion who had health problems associated with daily life. As previously reported, the introduction of three advanced nurse practitioners who could prescribe medicines and the realignment of the appointments schedule, particularly for minor illnesses, enabled the practice to manage the needs of this patient population. As before, this initiative had only been running since the end of 2014, having replaced the previously unpopular telephone triage system and so its effectiveness had not been fully evaluated.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and opportunistic smoking cessation advice.

The practice had identified those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group, and those who were receiving end-of-life care had a named GP who was responsible for their individual care plans. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including access to same-day appointments and clinical consultations on the telephone. For example, these patients had access to a dedicated mobile telephone number that was carried by the duty GP who could respond to any emerging needs.

Patients we spoke with on the day of our visit said they were satisfied that the practice was meeting their needs. Three of the 15 comment cards left by people visiting the practice prior to our visit expressed a view on the practice's responsiveness to their needs. All three of these views were positive.

The practice took account of initiatives or directives from the local CCG. For example, they had undertaken a review of every registered patient that was being prescribed particular types of opioid analgesics, certain anti-depressants and anti-convulsant medicines and other medicines known as hypnotics with the overall aim of reducing dependency. This had led to medication reviews and changes to the prescriptions of a significant number of those patients, in terms of dosage and timeliness of prescription issue.

Incidentally, the practice held a firm view that this robust approach to the prescribing of these medicines had led to many of the adverse review comments they had received on the NHS Choices web-site. Although the timescale in which these reviews were left indicate that this might have been the case, there was little other evidence to support this assertion as most of those comments had been anonymous.

Tackle inequity and promote equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability, patients with mental ill-health and patients living with dementia. Such patients were recalled for an annual, face-to-face health review, although the number of patients with mental ill-health who had

Good

Are services responsive to people's needs?

(for example, to feedback?)

individualised care plans had been around half the national average according to national data available in March 2014, this figure had increased to 83% according to the latest data. We saw that the practice ran checks of the data on their patient record system to monitor whether these groups of patients were taking up the appointments offered for a review of their physical health and those that did not respond were offered this opportunistically when they next attended the practice. Patients with mental health needs or those with learning disabilities were able to book consecutive appointments in advance to see the GP of their choice.

We also saw that the practice was configured on one floor in a way that enabled patients in wheelchairs or parents with pushchairs to access their GP or nurse. There was level access throughout with an automatic front door, widened doorways, an accessible toilet and a low level reception desk.

We saw that the practice web-site had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice and about NHS primary medical care. We saw that interpreters were arranged in advance and that extended appointments could be booked to facilitate this on the infrequent occasions this occurred.

Patients who were short term visitors to the area, such as members of the travelling community or recently arrived migrants, could access care where this was immediately necessary and by registering as a temporary resident. However, we learned that those occasions had been very few.

Access to the service

The practice offered appointments that could be booked up to four weeks in advance for GPs and nurse led clinics. Additional appointments were also released in stages; five days in advance, two days in advance then on-the-day. Patients could book appointments over the telephone, in person or by registering to use an online facility governed by the practice's electronic patient record system, although only GP appointments could be booked online. Some of the daily appointments were specifically held for minor illnesses run by the nurses, a service that had been implemented only short time before our inspection.

Patients who wished to be seen in an emergency were offered an appointment towards the end of surgery opening times with each GP having an additional six appointments and the 'duty GP' a further four. The practice manager explained that the number of emergency appointments had been set to fulfil an anticipated need based on historical demand although this demand was changing due to the recent introduction of the minor illness service that replaced the telephone triage system.

The practice also offered telephone consultations where patients needed to speak with a GP but they could be called in to attend if their problem was subsequently found to require a face-to-face consultation. A small proportion of appointments were held each afternoon for this reason or in case a GP wanted a patient to come in to discuss test results, for example. GPs carried out home visits to patients who were not able to get the practice.

The practice is located in an area which has a slightly higher than average proportion of working age people. However, there were no extended hours appointments offered with the practice opening hours set at 8:30am to 6:30pm each weekday. The 2015 National Patient Survey results showed that patient satisfaction with the practice's opening hours was among the lower 25% in the country. Outside of these hours patients were directed to the NHS 111 service.

The National Patient Survey showed that patients' satisfaction with their experience of making an appointment was among the lowest in the CCG area. This was also significantly lower than the national average, although the proportion of patients who said they were seen the next day was similar to expected. Five of the nine reviews on the NHS Choices web-site from 2014 commented adversely about appointment availability. We noted that these comments related to visits that pre-dated the introduction of the minor illness service.

Only one of the patients who left comment cards for us reported not being able to get an appointment and both patients we spoke with said they had never had any problems getting an appointment. We looked at the appointments schedule with the practice manager. We saw that, on the day of our inspection, four GP appointments had not been taken up and six minor illness appointment slots had not been filled. We looked at two other days on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice system and noted that appointments were often left unfilled; for example, 11 appointments had not been taken up on the Monday of that week, two days prior to our inspection.

This was at odds with the historical views of patients expressed through the National Patient Survey and the NHS Choices web-site. The reconfiguration of the appointments and the minor illness service that had recently been introduced had not, therefore, been formally evaluated. However, the practice was confident that this was having a positive effect on patient access and that this would be assessed through the 'Friends and Family' test and the prevalence of complaints.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. There was information in leaflet form in the reception area and in a notice on the notice board advising patients of the complaints procedure. However the information on the practice web-site was limited as it did not provide full details about how to complaint or who to refer to if the matter was not dealt with satisfactorily. Further, the information in the complaints leaflet about how to contact NHS England was out of date and there was no information about how patients might access advocacy to support them in making a complaint.

The practice web-site invited patients to comment or make suggestions by completing an online form. Both patients we spoke with said they had never had cause to complain but would raise it with the practice manager if they felt the need to do so.

We looked at a summary of the complaints received in the last 12 months and saw that these were satisfactorily handled and dealt with in a timely way, with appropriate written acknowledgement sent on receipt and written outcomes sent once the complaint had been dealt with. In a significant number of the complaints the practice had apologised to the complainant and had documented action they had taken to resolve the matter. For example, we saw three complaints about the telephone lines not being answered where patients had received an apology and steps were taken to have a previously undetected fault on the telephone lines repaired.

We also saw that the practice reacted appropriately to complaints about clinical issues. For example, we have reported above on a complaint about a prescribing issue where a comprehensive root cause analysis was carried out. In that instance, a number of clear action points had been identified with the practice manager designated as the person responsible for implementing changes and communicating these to staff.

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 staff had a shared understanding of the importance of putting patients' needs first. The practice information leaflet, available in hard copy form the reception area, carried a statement entitled 'practice charter' which set out a comprehensive set of principles and standards that patients could expect from the practice and the staff. This included the patient's right to express a preference about their practitioner, to be treated with courtesy and consideration, to experience the highest standards of care and to receive appropriate information about their condition and treatment. The statement also asserted that the practice would educate patients about their health and would safeguard their personal information.

There was also a laminated 'dignity code' prominently displayed in the reception area. This was a statement about what patients could expect in order to preserve their dignity. We spoke with staff at all levels of the practice on the day of our inspection and found that there was an overall commitment to these values of providing high quality, dignified care, a positive experience for patients and putting outcomes for patients first.

Although the practice had taken some recent significant steps in relation recruiting clinical staff and changing their resourcing model and appointments structure, this was not formalised in any clear, documented vision or strategy. There was also no long term business plan that set out any goals for the practice against which its progress might be measured. Whilst the recent changes indicated that the practice was responsive and had a firm commitment to improving, the absence of a vision or strategy showed that its approach was very much reactive as opposed to proactive. As a result, there was limited opportunity to develop organisational learning or to tailor future services based on how well such a strategy might be working.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. The practice had identified a lead clinician for each specialist clinical area, such as coronary heart disease, chronic kidney disease, diabetes, chronic lung conditions and people approaching the end of their lives. They were responsible for providing clinical direction to the practice's approach to these conditions.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The QOF is a database used by GPs to measure their performance against certain criteria that affects the way practises are funded.

The practice also actively used feedback form complaints, concerns and the findings of significant event analyses (SEA) and clinical audits in order to understand and manage any risks to their service. We looked at a number of examples of each of these as previously set out earlier in this report.

Decision making and communication across the workforce was structured around key, scheduled meetings. Business meetings took place monthly, or more frequently when required, involving the practice partners and the practice manager, where significant event analyses, QOF data, audits and clinical issues were discussed. The staff team were briefed about any changes as and when they occurred but in any event at half-day protected learning time (PLT) sessions once every month at which they were all present or by notifications by email. In addition to these meetings, the nursing team had weekly meetings during which they kept up to date with matters affecting their role and took part in clinical supervision.

The practice had a range of up-to-date policies and protocols, including patient group directions for certain medicines that were all available electronically and in hard copy.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The GP partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Staff we spoke with told us they felt confident they could raise any issues with the GPs or the practice management team.

Are services well-led?

Good

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

We noted that there was no staff room and staff had to take meals and other breaks at their desks. We acknowledge that this was due to limited space, however, it inhibited the ability of staff to effectively refresh themselves away from their work.

The practice manager explained that there had been a historically high turnover of staff in all roles but that recently the workforce had become more stable. We noted that staff were positive in their attitudes and presented as a happy workforce. They told us they felt supported and valued. For example, we noted that the arrangements for providing clinical supervision and support to the team of advanced nurse practitioners was very well received. We considered this to be evidence of the effectiveness of the leadership approach adopted by the practice.

There were robust policies in place that had the practical effect of supporting staff. For example, we noted that there was a zero tolerance policy in place in relation to abuse or violence towards staff and this was overtly publicised in the practice and on the web-site. This demonstrated that staff safety and wellbeing was a priority.

Seeking and acting on feedback from patients, public and staff

The practice did not have an active patient participation group (PPG), a group made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. We learned that previous attempts to form a PPG had been poorly received and had not resulted in enough patients volunteering to participate. The practice had run several recruitment campaigns to try and introduce the PPG through advertising in the reception and on the web-site and by hosting events at the surgery to promote the concept. At the time of our inspection, however, there was no literature or information available in the practice or on the web-site seeking patients' support for a PPG.

The practice acknowledged that they would have difficulty in meeting this when it became a requirement of their contract in the coming year. Nonetheless, we were assured by the practice manager that they would continue to try to seek patient participation explore the possibility of a 'virtual' PPG (a group that exchanges ideas and feedback electronically).

Although there was no PPG in place, the practice still actively sought feedback from patients, such as the dedicated section of their web-site that asked patients to submit comments, complaints or compliments and the suggestions box in reception. We saw that the practice acted on patient feedback; for example, the previously reported change in the appointments routine in response to adverse reviews. The practice had also rigorously implemented the 'Friends and Family' test with a prominent display in the reception area requesting feedback by way of questionnaire. We looked at the very latest report of the analysis of these questionnaires from February 2015 and saw that it contained predominantly positive feedback.

Staff told us that the practice acted on their feedback. For example, one of the nurses told us that the practice had adopted her suggestions about the use of a particular type of medicine used in treating diabetes. The practice had also stopped near patient testing for suspected thromboses due to the limited scope to carry these out and the infrequency they were required. Instead the practice referred such patients to another local practice and this had also been as a result of suggestions from the nursing team.

The practice had a whistleblowing policy which was available to all staff in hard copy and electronically on the practice computer system although we learned that this had not been used.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by opportunities for learning through PLT sessions. Of particular note was the support offered to the team of advanced nurse practitioners that we have reported on above.

Staff appraisals occurred annually although this years had been delayed for non-clinical staff.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.

Are services well-led?

Good

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

There were effective procedures for managing poor or variable performance and we learned of examples when this had happened.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was because there were no assessments in place in relation to the risks presented by the premises, such as a fire risk assessment or a water-borne infections risk assessment. There was also no means of identifying and capturing any emerging risks and logging action taken to mitigate those risks. There was no contingency plan in place to enable the practice to ensure patients received continuity of care in the event of a major incident or emergency that affected its ability to do so. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) and 17 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.