Featherstone Family Health Centre

Quality Report

Featherstone Family Health Centre
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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

Specifically, we found the practice to be good for responsive, effective, caring and well led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health. 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. However, although information about safety was reported monitored and reviewed, records to demonstrate how issues were addressed were not consistently recorded.
- Risks to patients were assessed and well managed, with the exception of those relating to undertaking a legionella assessment of the premises.
- 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.
- Patients said that they found it easy to make an appointment with a named GP and urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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.

We saw two areas of outstanding practice:

- The practice actively engaged with two traveller communities who lived on designated traveller sites and promoted health screening by visiting them in the community. The practice offered them the opportunity to register as permanent or temporary patients.
- The practice worked closely with the local community and council to review the living arrangements of patients whose lack of a residence was having an increasing adverse effect on their health.

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

Action the provider must take to improve:

- Ensure that a legionella risk assessment of the premises is carried out and systems put in place to prevent, control, monitor and manage any risks identified.

Action the provider SHOULD take to improve:

- Ensure consistency in recording the analysis and outcome of investigations of safety incidents, significant events and complaints.
- Document health and safety assessments to demonstrate whether any specific risks related to the practice have been identified, appropriate action taken and risk assessments put in place to mitigate the risk.

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 were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable patients who used the service. There was regular monitoring of safety to ensure that ways to improve were identified and implemented. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. However, the practice was not consistent in recording the analysis and outcome of investigations of all safety incidents. Lessons were learned and communicated widely to support improvement. Patients who used the service told us that they felt safe. There were enough staff to keep people safe. A legionella risk assessment of the premises was not completed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff told us that they referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Formal systems were in place to show that NICE guidelines and its implications for the practice was regularly discussed at staff meetings. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good 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. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care was positive. Data showed that patients rated the practice at or above average 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 to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and were aware of the importance of maintaining confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients

Summary of findings

that were over and above its contractual obligations. For example the practice actively provided a service to two communities of people who were travellers. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care and hospital admission avoidance. The care plans included an ex-directory telephone number that older patients could use if they needed to contact the practice in an emergency. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 years had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Data available demonstrated that year upon year the practice had consistently performed above the local and national average for meeting the needs of patients with long-term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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

Summary of findings

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice held evening appointments each week and welcomed enquiries via email.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for being responsive to the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. The practice offered longer appointments for patients with a learning disability. The practice provided a service to two communities of people who were travellers. The practice offered them the opportunity to register as permanent or temporary patients. The practice worked with both communities to encourage and educate them on areas such as the importance of health screening and immunisation of babies and young children. To support this staff from the practice visited these communities in their own environment and arranged meetings with the families and identified leaders within both communities. The practice had systems in place to share information with other health professionals that these patients may be in contact with when travelling.

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). All people experiencing poor mental health had a comprehensive care plan and had received an annual physical health check. The practice had identified patients with dementia and these patients had been included in the register of patients at risk of unplanned admission to hospital. All patients with dementia had personalised care plans developed which helped them and their carers to plan their care appropriate support. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

We spoke with thirteen patients during our inspection, two of whom were members of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were treated with respect, extremely satisfied with their care and treated with compassion. Patient's described the staff and GPs as excellent and told us that they were listened to by staff.

We reviewed the 45 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments made were positive about the service they experienced. Patients said that staff talked to them correctly, were professional, listened to them and offered an excellent service. They said staff treated them with dignity and respect, and were friendly and approachable.

The January – March 2014 and July – September 2014 national GP patient survey showed that practice performed well in all areas. These included:

- 95% of respondents usually wait 15 minutes or less after their appointment time to be seen as compared with the local CCG average of 69%
- 99% of respondents found it easy to get through to this surgery by phone as compared with the local CCG average of 73%
- 100% of respondents had confidence and trust in the last nurse they saw or spoke to as compared with the local CCG average of 98%
- 99% of respondents had confidence and trust in the last GP they saw or spoke to as compared with the local CCG average of 97%
- 99% of respondents say the last nurse they saw or spoke to was good at giving them enough time as compared with the local CCG average of 94%
- 98% of respondents said that the GP gave them enough time as compared with the local CCG average of 68%
- 89% of respondents said that said that they would recommend the practice to others as compared to the local CCG average of 61%

Areas for improvement

Action the service MUST take to improve

- Ensure that a legionella risk assessment of the premises is carried out and systems put in place to prevent, control, monitor and manage any risks identified.

Action the service SHOULD take to improve

- Ensure consistency in recording the analysis and outcome of investigations of safety incidents, significant events and complaints.
- Document health and safety assessments to demonstrate whether any specific risks related to the practice have been identified, appropriate action taken and risk assessments put in place to mitigate the risk.

Summary of findings

Outstanding practice

- The practice actively engaged with two traveller communities who lived on designated traveller sites and promoted health screening by visiting them in the community. The practice offered them the opportunity to register as permanent or temporary patients.
- The practice worked closely with the local community and council to review the living arrangements of patients whose lack of a residence was having an increasing adverse effect on their health.

Featherstone Family Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team included a GP, practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Featherstone Family Health Centre

Featherstone Family Health Centre provides services for 4,600 patients living in the Featherstone area of Wolverhampton. The practice is situated within an area where there are pockets of deprivation. The practice provides a service to a significant number of children and young adults. Their main population group are patients aged between 40 and 59.

The practice is a purpose built single storey building which was originally built by the current lead GP in 1991. The practice built an extension to the existing building in 2010 in response to requests from the local community for improved medical services. It also offers on-site parking, wheelchair and step-free access. The opening times at the practice are between 8am and 6pm Monday to Friday. Patients can book appointments in person, on-line or by telephone. Extended hours are available on Monday evening between 6.30pm and 8.30pm.

The practice provides services to patients of all ages based on a Primary Medical Services (PMS) contract with NHS England for delivering primary care services to their local community. Services provided at Featherstone Family Health Centre include the following clinics; family planning, new patient medical health checks, asthma, diabetic, baby vaccination and wellbeing screening clinics.

The team of clinical staff at the practice is made up of two practice nurses (female), two healthcare assistants and three GP Partners two male and one female. The GPs provide the equivalent hours of two full time GPs. A practice manager, reception, administrative and secretarial staff provide management and administration support for the practice.

Featherstone Family Health Centre is an approved GP training practice for Registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine).

Primecare provides an out of hours service for patients when the practice is closed and information is provided to patients about how to access out of hours care 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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group and the local Healthwatch to tell us what they knew about Featherstone Family Health Centre and the services they provided. We reviewed information we received from the practice prior to the inspection.

We carried out an announced visit on 3 March 2015. During our visit we spoke with a range of staff including two GPs, salaried Registrar, the practice manager, two practice nurses and seven reception and administration staff. We spoke with 13 patients this included two members of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. The practice had a system in place for reporting, recording and monitoring significant events, incidents, accidents and national patient safety alerts as well as comments and complaints received from patients. There were records of significant events that had occurred during the last year and we were able to review these. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, concerns were identified where patients records had not been accurately scanned into patient records. Systems were put into place to monitor the accuracy of the scanning of patient information into their records and the importance of this shared with staff.

We found however, that some of the safety records we looked at did not contain sufficient detail to demonstrate a safe track record within the practice over the long term. We saw that incident reports, complaints and notes of meetings did not consistently demonstrate the investigations carried out, action taken, discussions that had taken place or the learning shared with staff. For example the minutes of a significant event meeting held on 10 November 2014 detailed two significant events that had occurred. We found that only one contained sufficient detail to demonstrate a full review of the incident. Regular meetings were not held by the practice to review actions from past significant events. We were reassured by the practice that they would address this.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We were shown three significant events that had occurred over the last year and saw that these were completed in a timely manner. We saw evidence of learning following one of the significant events. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were received by one of the GPs. The GP looked at the key messages in the alert and then disseminated these to relevant staff.

Learning and improvement from safety incidents

We saw that significant events although not a regular item on the agenda were discussed at practice meetings. We tracked the three significant events. There was evidence although not consistently recorded that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw that working practices that could affect patient safety were also discussed for example, when the practice found that results from tests they had carried out were not available; they examined the specimen collection, transportation and delivery process in place. They identified that although the specimens taken were recorded in patients records they could not be sure that specimens had been collected and delivered to external organisations for testing. We saw that appropriate action had been taken and the issue was raised as a significant event. Following analysis of the significant event we saw that a daily log of all specimens sent to external organisations for testing was maintained. Reception staff ensured that all specimens had been logged. The log enabled the practice to have an audit trail of specimens in transit to external organisations.

Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice staff also told us that alerts were discussed at monthly staff meetings and at protected learning sessions to ensure all staff were aware of any actions they may need to take. Information we read in meeting minutes confirmed this. For example we saw that the practice had taken action to address two recent safety alerts. We saw that following receipt of these alerts that appropriate action had been taken to review patient care and treatment. This included a review of insulin pumps used by patients following the identified risk of hyperglycaemia (high blood sugar) or hypoglycaemia (low blood sugar) with a specific insulin pump if the pump's power was interrupted. Insulin pumps are pieces of equipment used to support some patients in the control of their diabetes.

We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us that they had no concerns about this practice.

Requires improvement

Are services safe?

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed throughout the practice.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had appropriate training to enable them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Practice staff told us that when they received accident and emergency (A&E) discharge letters that they were reviewed by a GP. This included identifying and reviewing vulnerable adults and children with a high number of A&E attendances.

There was a chaperone policy, which staff could access through the practice IT system. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Information leaflets on the role of a chaperone were available for patients and staff. Signs were also displayed throughout the practice informing patients of their right to have a chaperone present during an intimate examination. Nursing staff clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse. Reception staff had received formal training to undertake chaperone duties if nursing staff were not available. These staff had DBS criminal records checks completed. DBS checks were carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The receptionists recognised the need to be able to clearly observe the examination and were aware of what action to take if they had any concerns.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

A log of the fridges' temperature had been recorded daily which demonstrated that vaccines in the fridges were stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff that we spoke with understood why and how to follow the procedures identified in the policy.

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

We saw records of audits that identified best practice actions to be taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing for patients who presented with symptoms related to chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Action taken following the medicines audits included ensuring that all clinicians had prescribed in line with national and local prescribing guidelines and evidencing change in prescribing habits where needed in line with the guidelines.

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

and covered all required areas. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat medicines were appropriate and necessary.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there was a cleaning schedule in place and records were available to monitor that cleaning had been carried out daily and in line with the cleaning schedule. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. This was also confirmed in some of the patient comment cards we received. The practice carried out spot checks on consulting and treatment rooms. We saw information that showed that where concerns had been raised about the cleanliness of these rooms these were discussed with the practice manager who addressed the concerns with the practice cleaners.

The practice had a lead for infection control who had completed audits related to infection prevention and control. The lead for infection control had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Training records for staff showed that both clinical and non-clinical staff had received infection control training. We saw evidence that the lead had carried out regular infection control audits and that any improvements identified for action were completed on time.

The infection control policy supported staff to plan and implement measures to control infection. For example, personal protective equipment included disposable gloves and aprons and these were available for staff to use. Staff described how they would use these to comply with the practice's infection control policy. For example when dealing with spills of blood or bodily fluids. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Staff told us that they were aware of the policies and where to find them if they needed to refer to them. There was a policy for needle stick injuries and staff knew what to do if an injury occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had procedures in place to protect staff and patients from the risks of health care associated infections. We saw records that demonstrated that clinical staff had received the relevant immunisations and support to manage these risks.

We saw that although the practice had some procedures in place to prevent the growth of legionella, they could not confirm that a legionella risk assessment had been completed at the premises. For example we were told that the cleaning staff flushed the taps by running them on a regular basis and took the temperature of the water, however this information was not recorded. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw records that demonstrated all portable electrical equipment had been tested in March 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in November 2014 to ensure the information they provided was accurate. This included devices such as weighing scales, blood pressure measuring devices and medicine refrigerators.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included proof of identification, references, a full work history, qualifications and up to date registration with the appropriate professional body.

We saw that Disclosure and Barring Service checks (DBS) had been carried out for both clinical and non-clinical staff working at the practice. DBS checks were carried out to 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.

Requires improvement

Are services safe?

We saw that the practice employed sufficient and suitable staff to meet the needs of their patients. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that staffing rotas were planned in advance to ensure adequate staffing levels were maintained.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that regular checks of the building had been carried out. This included a fire risk assessment in February 2015 and fire drills for staff; gas safety checks; emergency lighting tests; automatic doors maintenance and fire alarm testing. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed in February 2015. However the practice did not have information available to show that legionella risk assessments had been carried out.

The practice had a designated lead for health and safety. The practice manager told us that visual health and safety assessments were carried out, however these were not documented to demonstrate whether any specific risks related to the practice had been identified to demonstrate action taken or put in place.

The practice had emergency processes in place for identifying acutely ill children and young people. Staff we spoke with told us that children were always provided with an on the day appointment if required. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff told us that patients would be referred immediately and an emergency ambulance called if needed.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with emergencies that may impact on the daily operation of the practice and affect providing a safe service to patients. Risks identified included power failure, adverse weather, unplanned sickness and the loss of domestic services. We saw that emergency lighting checks and fire risk assessments that included actions required to maintain safety had been carried out. Each risk was rated and mitigating actions recorded to reduce and manage the risk. For example, temporary premises and the plans for longer term premises were identified. Records showed that staff were up to date with fire training and that practice fire drills had been carried out this year. Records we looked at showed that fire safety risk assessments had been completed in February 2015 and the last fire drill carried out in December 2014. Staff also confirmed that they had taken part in fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, the GPs and nurses described how they had used the NICE guidelines for the management of patients with long-term conditions such as diabetes, chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. We saw that guidelines were also followed to manage the care of children presenting with a high temperature. We saw that the GPs and nurses used clinical templates in the management of patients care and treatment. This assisted them to assess the needs of patients with long-term conditions and older patients for example. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice had identified 260 patients with diabetes. We saw that these patients had individual care plans which included information about their condition, individual symptoms and signs that would be normal for them and what action they or their carer should take in the event of an emergency or a change in their health due to illness. Patients had a full review of their plans annually and a review of their care at regular intervals throughout the year. Data from the local Clinical Commissioning Group (CCG) who monitored the performance of the practice showed that patients at this practice who experienced poor mental health (including those with dementia) had higher than local average outcomes in all areas. For example, The practice had 26 patients on their mental health register and all had a comprehensive care plan and had received a physical health check in the previous 12 months. This was higher than the local CCG average of 76%. The practice had identified 19 patients with dementia and these patients had been included in the register of patients at risk of unplanned admission to hospital. All patients with dementia had personalised care plans developed which helped them and their carers to plan their care appropriate support.

The GPs told us they led in specialist clinical areas such as obstetrics and gynaecology, psychiatry and misuse of substances. We saw training certificates which demonstrated that practice nurses had received the additional training they required for the review of patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Clinical staff told us they continually reviewed and discussed new best practice guidelines. The minutes of practice meetings confirmed learning was shared between clinicians and best guidance was discussed which led to a change in practise where required.

All the GPs we spoke with used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks. The practice had identified one occasion when a timely referral had not been made. This was identified as a significant event and reviewed to so that systems could be put in place to prevent this happening again. Staff ensured that these referrals were appropriately entered and coded on the patient information system.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by identified staff to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken over the last 12 months. One of the audits was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit to review the increased prescribing rates of an antibiotic for patients, adults and children who presented with chest infections. The practice reviewed their practice in line with national and local guidance and advise

received from the Clinical Commissioning Group (CCG) prescribing advisor. The aim of the audit was to assess antibiotic prescribing practise with a view to reducing the frequency of antibiotic use and improving the appropriateness of prescribing. After two cycles of this audit the practice were able to demonstrate a reduction in the use of antibiotics. The practice also identified the need to provide education for patients on the use of antibiotics. The practice had also completed audits on the types of minor surgery carried out at the practice, the accuracy of diagnosis and the documentation of informed consent when undertaking minor surgery procedures. The outcome of this audit showed a 95% accuracy in diagnosis and 100% appropriately completed consent forms recorded in patients records.

We looked at data from the quality and outcomes framework (QOF) for 2013/2014. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. We saw that the practice had achieved 98% of the QOF points available to them; this was higher than the England average of 94%. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The lead nurse and practice manager were responsible for ensuring that patients on registers due to high health needs had received the reviews they required as part of their illness or condition. These groups of patients included those with long term conditions, for example patients with diabetes, heart failure or asthma. The CCG data we reviewed confirmed that the practice had continuously performed at a significantly high level in all clinical areas.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, all patients with cancer were reviewed within three months of diagnosis. We also saw records that showed that GPs had reviewed the timeline to diagnosis for 16 patients diagnosed with cancer. These patients had been reviewed and their treatment and management history presented at clinical meetings. Clinical staff told us this helped staff to reflect on whether action could have been taken sooner to ensure that all patients with suspected cancer are referred in a timely way, appropriately and managed effectively. The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw there was a system in place that identified patients approaching the end of their life. This included working with other health and social care professionals, maintaining a palliative care register of patients and alerts within the clinical computer system to make clinical staff aware of their additional needs.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice information technology (IT) system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question. Where the GPs continued to prescribe the medicine they outlined the reason why this decision had been made. The practice also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with confirmed that their medicines were regularly reviewed.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data highlighted areas where the practice was performing well and areas they needed to improve. QOF data demonstrated that year upon year that the practice consistently performed above the local and national average across all clinical areas.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that clinical and non-clinical staff were up to date with attending training courses such as basic life support, infection control and prevention and safeguarding. We noted a good skill mix among the GPs and practice nurses. GPs specialist interests included obstetrics and gynaecology and mental health and they had appropriate courses and qualifications in these areas. All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is

appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All nurses and healthcare assistants had supervision of their practice carried out every three months. All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The practice was a training practice, GP registrars who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and extended roles. The nurses were able to demonstrate that they were trained to fulfil these duties. For example, nurses had diplomas in diabetes and asthma care and had completed appropriate training to undertake the administration of childhood immunisations, vaccinations and cervical screening. GP support was available to practice nurses at all times.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked well with other local authority and health services. This included midwives who assisted in the provision of antenatal clinics to pregnant women and health visitors who supported the care of babies and young children and carried out baby clinics. The practice held multidisciplinary team meetings every six weeks to discuss the needs of complex patients, for example those with end of life care needs or children classed as at risk. The meetings were attended by district nurses, social workers, community matrons and palliative care nurses. Decisions about care planning were documented in a shared care record. The practice worked closely with local community support organisations to support and enhance patient care. The practice also worked closely with the local clinical commissioning group (CCG) prescribing advisor who supported the practice in the effective review and management of medicine prescribing.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice told us that all possible referrals had been made using the 'Choose and Book' system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had a system in place for dealing with test results. These were reviewed by the relevant GP. If the GP was not available the duty GP for the day was responsible for reviewing the results.

Patients were encouraged to sign up to the electronic Summary Care Record. This record would provide health care staff treating patients in an emergency or out of hours with faster access to key clinical information. Patients had access to information about the Summary Care Records on the practice website and in posters at the practice. Patients were also made aware that they could choose to opt out of signing up to these.

Consent to care and treatment

There were systems in place to seek record and review consent decisions. For example, where verbal consent was required for intimate procedures, a patient's verbal consent was documented in their electronic records. For other

procedures, including minor surgery written consent was obtained. We saw a form that patients signed to acknowledge that the procedure, the benefits and risks had been explained to them before they gave their consent.

We saw that patients had signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing to. The plans included details of the patients preferences for treatment and decisions. Staff at the practice told us copies of the care plans were kept in their homes. Some of the patients we spoke with confirmed this.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. We saw that where there had been best interest meetings that were documented with details of the outcome. All clinical and non-clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We saw that staff had attended recent training on mental capacity and DoLS (Deprivation of Liberty Safeguards) The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. These safeguards aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Health promotion and prevention

It was practice policy to offer an annual health check to all new patients registering with the practice and patients aged 75 years or over. The practice had offered NHS Health checks to 502 of its eligible patients aged between 40 to 74 years. Information available showed that 169 (34%) had taken up this offer and had a health check completed. These checks included a cholesterol test, blood pressure check, weight and lifestyle management advice. The GP was informed of all health concerns detected and these were followed up in a timely way. We saw notices in the waiting room that made patients aware that these health checks were available. The practice actively engaged their patients in lifestyle programmes. The practice had recorded the smoking status of 87.4% of their patients over the age of 15 this level was similar to the local and national rates. The practice nurse described to us how they sign posted patients to smoking cessation courses. The practice data showed that 74 patients had accessed the course, 37 (52%) patients quit smoking and of these 22 patients quit smoking in 12 weeks.

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was performing above average when compared with the local Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations. The practice offered travel vaccines and flu vaccinations in line with current national guidance. The Quality Outcome Framework (QOF) data showed that the practice was performing above national standards in providing flu immunisations for the target groups of patients.

There were systems in place to support the early identification of cancers. Information we reviewed showed that the uptake of female patients aged 50-70 years screened for breast cancer within six months of invitation was 81.5% as compared to the national average of 71.4%. The uptake of cervical screening for female patients between the ages of 25 and 64 years was 81.6%, this figure was higher than the local and national of 77.3% and 74.3% respectively. Patients who did not attend for cervical screening were offered various reminders, by telephone and letters for example and the practice audited non-attenders annually. The practice offered a free and confidential Chlamydia screening service for all 16 to 24 year olds. Family planning services were provided by the practice.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept registers of their patients who would be considered at risk and or vulnerable. These included a register of patients with learning disabilities, patients experiencing mental health problems, patients with diabetes and patients

Good

Are services effective?

(for example, treatment is effective)

identified as likely to be admitted to hospital. Patients with a learning disability had a care plan completed and all these patients received an annual physical health check by the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 107 replies to the national patient survey carried out during January-March 2014 and July-September 2014. The evidence showed that patients were generally satisfied with how they were treated. The results from the national patient survey showed that all respondents said that their overall experience of the practice was good or very good and 99% of respondents said they would recommend the practice to someone new to the area. These results were above the national average of 68% and 61% respectively. The National patient survey results showed that the respondents rated the practice highly overall for example, 99% of respondents said the GP was good at listening to them and 98% said the GP gave them enough time. The national average for both these responses were 68%. The results also showed that the practice was above the national average for its satisfaction scores on consultations with nurses. For example, 91% of respondents said the nurse was good at listening to them and 92% of respondents said the nurse gave them enough time. The national average was 62% and 61% respectively.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 45 completed cards and they were generally positive about the service they experienced. Patients said the practice was welcoming, staff were caring, polite and understanding, and that staff treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. We also spoke with thirteen patients on the day of our inspection and their comments reflected comments we received in the comment cards.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Reception staff that we spoke with were aware of systems in place to maintain patient's confidentiality. These included taking patients to a private room to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the practice for investigation results.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responses to questions about their involvement in planning and making decisions about their care and treatment generally rated the practice as good or very good in these areas. For example, data from the national patient survey showed 92% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these results were above the national average of 64% and 67% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. We saw that the practice provided patients with information on their

condition to support self-care. Patients were informed about the frequency of reviews, equipment, medicines or specimens they should bring with them when attending their review appointment.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 99% of respondents to the 2014 national patient survey said the last GP they saw or spoke with was good at treating them with care and concern with a score of 90% for the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, comments made highlighted that staff responded compassionately when they needed help and provided support when required.

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

We saw that patient electronic records had the name of their carer documented where this was applicable. The lead GP told us that patient deaths were recorded in the patient electronic record. If families had suffered a bereavement, their usual GP contacted them and a 'face to face' visit arranged if patient wanted this. If necessary staff also signposted or referred patients to bereavement support and counselling services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood for example, the practice held a register of patients identified as homeless. We saw that the practice worked closely with the local community and council to review the living arrangements of patients whose lack of a residence was having an increasing adverse effect on their health. The practice also provided a service to two travelling communities. The practice worked with both communities to encourage and educate them on areas such as the importance of health screening and immunisation of babies and young children. To support this staff from the practice visited these communities in their own environment and arranged meetings with the families and identified leaders within the community. The practice had systems in place to appropriately share information with other health professionals that these patients may be in contact with when travelling. The practice was able to demonstrate that these patients responded positively to this approach. Families attended appointments at the practice, welcomed staff into their homes to provide treatment and ensured children received their immunisations.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with two members of the PPG who told us about the patient survey in 2014 of 213 patients. The practice had divided the results of these into male and female responses. The results showed that 123 responses were received from female patients and 90 from male patients. Trends or differences between the two groups were not identified however, the results of the practice survey were in keeping with the results of the national patient survey. Some patients commented that they were not aware of all the services provided by the practice. In response to patient comments the practice had discussed with the PPG how they could address this. The practice looked at and made improvements to their patient communication systems. Details of the outcome of the patient survey together with the actions to address their comments were displayed on the patients notice boards in the reception area.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed they had completed equality and diversity training. We looked at staff training records at the practice and saw that it identified the staff who had completed this training online.

The practice recognised the needs of different groups in the planning of its services. The practice was a purpose built single storey building. The practice was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included identified parking spaces; level access to the automatic front doors of the practice; adapted toilet facilities to meet the needs of patients with disabilities and a hearing loop for patients with a hearing impairment.

The practice had a small population of patients of Asian origin. For patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

The practice provided care and support to several house bound elderly patients. Patients over 75 years of age had a named GP to ensure continuity of care. The practice provided care and treatment for a community of travellers. They told us that this community were supported to access health care services either as permanent or temporary patients with the practice whichever was more appropriate.

Access to the service

Comprehensive information was available to patients about appointments on the practice's website and in the practice leaflet. This included how to arrange routine and urgent appointments and home visits and how to cancel appointments through the website. There were also arrangements to ensure patients received urgent medical

Good

Are services responsive to people's needs?

(for example, to feedback?)

assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

We looked at the national patient survey results published in January 2015 and saw that 96% of respondents described their overall experience of making an appointment as good or very good. Patients we spoke with and comments made in comment cards also confirmed that patients found that appointments were easily accessible.

The normal opening hours for the practice were 8am to 6.30pm. The practice also offered extended hours outside of the practice normal working hours for patients unable to attend due to work commitments or rely on other people bringing them to the practice who go to work. Extended clinic hours were offered with a GP, nurse and healthcare assistant on a Monday evening between 6.30pm to 8.15pm. During the winter months the practice had also offered an additional clinic on Tuesday evening.

The practice offered pre-bookable appointments which patients could make up to two weeks in advance. For those patients who wished to be seen on the same day systems were in place for the designated duty GP to contact the patient by telephone to assess the persons clinical needs and make a decision as to whether an appointment was needed. The patient would then be booked an appointment to see the duty GP.

Longer appointments were available for patients who needed them, this included those with long-term conditions. The practice offered up to five telephone consultations per day after the morning clinic. Staff told us that children and older patients were always seen on the same day that they requested an appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that there was information on the practice website and a poster in the waiting room informing patients how to complain.

We looked at four complaints the practice had received in 2014. We saw they had been responded to and dealt with in a timely manner and found the practice demonstrated openness and transparency when dealing with complaints. We saw practice meeting minutes that demonstrated complaints were discussed and learning from them was shared with staff. This supported staff to learn and contribute to any improvement action that might have been required. We saw that lessons learned from individual complaints had been acted on.

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

We saw that the practice had written their vision for the practice in their statement of purpose. The practice values included: to provide people registered with the practice with high quality services; to involve patients in decisions about their care; to respect their religious and cultural beliefs; to ensure that patients were seen by the most appropriate healthcare professional as soon as possible and to ensure that all members of the practice team had the right skills and training to carry out their duties competently. We found that patients felt respected and said that they were involved in decisions about their care.

The practice did not display their vision within the practice so that these could be shared with patients and staff. The practice also did not have a written strategy or business plan in place. The practice told us that they would review this.

We spoke with a number of patients, staff and other health professionals who all spoke very positively about how the practice worked to fulfil its aims. Staff and members of the PPG told us that the practice continuously reviewed the services provided and introduced changes if they were appropriate to meet the needs of patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer at the practice. We saw that staff could easily access the policies. We looked at seven of the policies available and saw that they had been reviewed annually and were up to date. The practice collected evidence to confirm that staff had read and understood relevant policies that had been put in place. This was monitored by the practice manager and was also followed up at practice meetings and through staff appraisals.

There was clear strong leadership at the practice. Staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns. All staff had specific roles and could demonstrate that they took these seriously. For example, there was a lead nurse for infection control who ensured that audits completed involved all members of staff. A GP led on womens health with a special interest in obstetrics and gynaecology (the medical term for dealing with the health of the female reproductive system). Other lead roles included psychiatry and teaching.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing better than national standards with a practice value of 98% compared with a national value of 94%. We saw that QOF data was regularly discussed at monthly meetings. We saw that actions had been taken to maintain or improve patient outcomes. These included a review of the care of patients who had been diagnosed with cancer and a review of patients attending the accident and emergency department (A&E).

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at three, one of which was a completed audit. They all demonstrated good practise and improvements in outcomes. One example was an audit to check the appropriate prescribing of antibiotics. The audit had been shared with all staff and included discussion and peer review of each case. As a result learning had been shared between staff.

The practice had some systems in place for identifying, recording and managing risks. We found that not all systems were completely robust. For example, visual health and safety assessments carried out were not documented to demonstrate whether any specific risks related to the practice had been identified to demonstrate action taken or put in place. We also found that although staff told us that they had procedures in place to prevent the growth of legionella these were not documented. Staff at the practice were also not able to confirm that a legionella risk assessment had been completed at the premises. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that risk assessments had been carried out for the practice business continuity plan. For example, in the event of the loss of the main computer operating system, practice staff had

Are services well-led?

Good

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

identified systems to back-up patient information on an identified computer system and backup tapes were kept off site. This would allow staff to access patient information and guidelines in an emergency.

The practice held monthly governance meetings to which all staff were invited. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice worked very well as a team and comments received from staff confirmed this. Staff were aware of the management structure within the practice and felt that the team were strong and supportive. The practice manager was responsible for human resource policies and procedures. We reviewed eleven policies, for example safeguarding, equal opportunities, managing complaints, recruitment and disciplinary procedures which were in place to support staff. We were shown that policies and procedures were easily accessible on computers to all staff. Staff we spoke with knew where to find these policies if required.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. Other policies available included equality, whistleblowing, harassment and bullying at work. We found that not all staff were aware of how the whistle blowing policy worked. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. The management team assured us that how this policy worked and could be implemented if needed would be discussed with staff.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through surveys, comments, complaints, a compliments and suggestion box in the waiting room, and review of the GP national patient survey. The practice had an active patient participation group (PPG). The PPG had fifteen members which mainly represented the over 50 age group. The PPG was actively attempting to recruit and we saw notices advertising this displayed in the practice. The PPG had carried out yearly surveys and met every three months with practice staff including the practice manager and a GP. The practice manager showed us the analysis of the last patient survey. The minutes of the PPG meetings showed that the outcome of surveys had been discussed with the PPG.

One of the outcomes of the practice survey showed that some patients had expressed that they were not aware of all the services provided by the practice. In response to this the practice took action by updating details on their website, they introduced a practice newsletter, updated the information display system in the waiting room and ensured that patient noticeboards were updated so that patients had regular updates.

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

Management lead through learning and improvement

The staff we spoke with told us that they had been supported to develop skills and knowledge appropriate to their role. This was confirmed by the training certificates on staff files. We saw that nursing staff had completed additional qualifications and updated their skills to enable them to support the management of patients' health needs. An example was some nurses were trained to manage the treatment of patients with asthma and diabetes. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had monthly protected learning time. Learning was regularly shared and applied at all staff levels.

The practice was a training practice for GP registrars to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this.

Are services well-led?

Good

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

The practice GPs and nurses met on a weekly basis to discuss any clinical issues, guidelines or serious events. Staff showed they were keen to ensure ongoing improvement and addressed this as a team and through the patient participation group (PPG). An example of this was a review of patients who had undergone minor surgery procedures. This looked at the accuracy of diagnosis and the documentation of informed consent when undertaking minor surgery procedures. The outcome of this audit showed that the practice had performed very well with the accuracy of diagnosis and that all patients had an informed consent form recorded in their records.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found that the registered person could not demonstrate that they had completed a full assessment in relation to the risk of, prevention, detection and control of infections, including those that are health care associated because a legionella risk assessment had not been carried out and robust systems were not in place to confirm the control, monitoring and management for mitigating any risks. This was in breach of regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.