

The Park Medical Practice

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?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Outstanding	
Are services well-led?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Park Medical Practice on 18 November 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were comprehensively and systematically assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- An ethos of patient centred care was well established throughout the practice's work force. Staff had been proactive in setting up regular 'health walks' in the local park to promote a healthy lifestyle for patients and offer social opportunities for patients who may otherwise be isolated.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns. We saw that the practice took a transparent approach to the management of complaints in order to maximise learning opportunities.
- Patients said they mostly found it easy to make an appointment with a GP, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour.

We saw three areas of outstanding practice:

- The newly appointed clinical nurse specialist had identified and reviewed 185 patients at risk of having poorly controlled diabetes and offered lifestyle advice and changes to medication as appropriate. A total of 62 of these patients had already been recalled and attended for a further review following these changes being implemented. Of these 62, 59 had been found to have improved control of their condition.
- We saw that the practice routinely wrote to care homes in its catchment area on a quarterly basis to establish whether any of their patients had deprivation of liberties safeguards in place.
- Practice staff had set up a weekly “health walk” in the local park each Thursday morning, and invited

patients to attend. This promoted a healthy lifestyle as well as providing social interaction and networking opportunities for patients who otherwise may be isolated.

The areas where the provider should make improvement are:

- The planned training should be undertaken to ensure health care assistants are trained to an appropriate level in child safeguarding in line with recognised guidance. The planned appraisals for this group of staff should also be completed.
- Consider the simplification of documents available to staff for the management of incoming mail in order to further mitigate the risk of the GPs not having sight of correspondence they need to see.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. The practice intended to ensure that health care assistants received additional training around child safeguarding issues to consolidate this further.
- Risks to patients were comprehensively and regularly assessed and well managed.
- The practice had systems in place to manage incoming correspondence to the practice, although during the visit there was some confusion around which documents were in use to govern this activity.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally in line with the local and national averages.
- Staff assessed needs and delivered care in line with current evidence based guidance and we saw there were systems to ensure staff were kept up to date with any changes to best practice.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for most staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Patients told us during the inspection visit that practice staff and clinicians treated them with high level, quality care.
- Patients also said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- While data from the national GP patient survey reflected a positive view of these areas, results showed patients generally rated the practice lower than others for several aspects of care. The practice had recently recruited new clinicians which it felt would help address this.
- A member of the reception team had been recognised by the CCG for her contribution over and above the level expected in terms of customer service through the practice staff award in 2015.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Recent additions to the practice's clinical team had broadened the skill set available and had resulted in a measurable impact on patient outcomes, particularly around diabetes control.
- The newly appointed clinical nurse specialist had identified and reviewed 185 patients at risk of having poorly controlled diabetes and offered lifestyle advice and changes to medication as appropriate. A total of 62 of these patients had already been recalled and attended for a further review following these changes being implemented. Of these 62, 59 had been found to have improved control of their condition.
- Patients told us during the inspection that they found it easy to make an appointment with a GP, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Outstanding



Summary of findings

- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- Following a trend of patient feedback around difficulties with telephone access, the practice had identified busy periods and updated working practice so that additional administration staff logged their phone systems into the main line to help deal with the volume of calls. Patients told us this had resulted in quicker response times when contacting the practice by telephone.
- The practice offered insulin initiation services for diabetic patients as well as clinics to monitor anticoagulation medication for patients with atrial fibrillation. This minimised the need for additional visits to secondary care to access these services.

Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.
- The practice had a number of practice specific policies and procedures to govern activity.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included comprehensive arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Double appointments were offered to patients over the age of 75 to ensure they had sufficient time in consultations for their health needs to be met.
- Regular multidisciplinary team meetings were held to ensure the needs of those patients approaching end of life were met.

People with long term conditions

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

Outstanding



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The newly appointed clinical nurse specialist had identified and reviewed 185 patients at risk of having poorly controlled diabetes and offered lifestyle advice and changes to medication as appropriate. A total of 62 of these patients had already been recalled and attended for a further review following these changes being implemented. Of these 62, 59 had been found to have improved control of their condition.
- The practice was able to initiate insulin medication for diabetic patients, and had developed a “starting with insulin” information pack which was given to all of these patients which included useful advice and information.
- A podiatrist specialising in diabetic foot care regularly attended the practice.
- The practice offered twice weekly anticoagulation clinics where medication was monitored and dosage updated as required. This prevented the patients needing to attend further appointments in a secondary care setting in order to access this care.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Patients with complex needs and multiple conditions were offered a single holistic annual review of their needs, meaning they did not need to make multiple trips to the practice.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 76%, which was slightly lower than the CCG and national averages of 81%. However, the practice's exception reporting rate for this indicator was 6% lower than the local average and almost 4% lower than the national average.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

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 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.

Good



Summary of findings

- Appointments were available on a Saturday morning for those patients whose working patterns made it difficult for them to attend through the week.

People whose circumstances may make them vulnerable

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

Good



- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- A shared care substance misuse support worker offered regular clinics at the practice.

People experiencing poor mental health (including people with dementia)

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

Good



- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 88% compared to the CCG average of 89% and national average of 89%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 71% compared to the CCG average of 86% and national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice's clinical pharmacist had a background in specialist mental health care. He was undertaking the annual reviews for patients on the practice's mental health register and was offering these patients longer appointments in order to facilitate establishing a good rapport with them.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. The clinical pharmacist reviewed all discharge correspondence and followed up these patients as required.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. A total of 284 survey forms were distributed and 107 were returned. This represented a response rate of 38% and just under 1% of the practice's patient list.

- 75% of patients found it easy to get through to this practice by phone compared to the local average of 74% and national average of 73%.
- 80% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 78% and national average of 76%.
- 75% of patients described the overall experience of this GP practice as good compared to the local average of 87% and national average of 85%.
- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 81% and national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 22 comment cards all of which made positive remarks about the standard of care received. Many of the cards identified staff members by name to praise the high quality of care they had provided. Eight of the cards, in addition to making positive comments, also highlighted some areas of concern. These were mainly around appointments being difficult to obtain in a timely manner if a consultation with a specific GP was requested, a lack of continuity of care and a lack of the 'personal touch' making patients feel uneasy about discussing sensitive issues with staff. However, we also noted that four other cards explicitly praised the practice for the fact that appointments were always available when needed, and a further four made specific reference to how caring and empathetic the GPs and nurses were as well as the fact they were good at listening to patient's concerns.

We spoke with five patients during the inspection. All five patients said they were highly satisfied with the care they received and thought staff were approachable, committed and caring. All five told us that they were able to access appointments when they needed them and that they felt listened to and involved in their care when they spoke to clinicians.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The planned training should be undertaken to ensure health care assistants are trained to an appropriate level in child safeguarding in line with recognised guidance. The planned appraisals for this group of staff should also be completed.

- Consider the simplification of documents available to staff for the management of incoming mail in order to further mitigate the risk of the GPs not having sight of correspondence they need to see.

Outstanding practice

We saw three areas of outstanding practice:

- The newly appointed clinical nurse specialist had identified and reviewed 185 patients at risk of having poorly controlled diabetes and offered lifestyle

advice and changes to medication as appropriate. A total of 62 of these patients had already been

Summary of findings

recalled and attended for a further review following these changes being implemented. Of these 62, 59 had been found to have improved control of their condition.

- We saw that the practice routinely wrote to care homes in its catchment area on a quarterly basis to establish whether any of their patients had deprivation of liberties safeguards in place.
- Practice staff had set up a weekly “health walk” in the local park each Thursday morning, and invited patients to attend. This promoted a healthy lifestyle as well as providing social interaction and networking opportunities for patients who otherwise may be isolated.

The Park Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to The Park Medical Practice

The Park Medical Practice is situated in a purpose built health centre (Cottam Lane Surgery, Preston, PR2 1JR) on the outskirts of Preston. A pharmacy is also housed within the health centre building. The premises are accessible for patients experiencing difficulties with mobility and there is ample space for car parking, including designated disabled spaces close to the main entrance of the building.

The provider also delivers services from another location (New Hall Lane Surgery, Preston), but presently this site is registered as a separate location with the Care Quality Commission so was not inspected as part of this visit. The practice informed us they were in the process of de-registering the New Hall Lane surgery as it was operated as a branch surgery from the main site at Cottam Lane. The practice had also recently merged with another practice (Dr Nath's practice) which was also situated in the Cottam Lane surgery.

The practice is part of the NHS Greater Preston Clinical Commissioning Group (CCG) and delivers primary medical services to a patient population of 14,153 patients via a general medical services contract with NHS England. The

practice has one contract with NHS England that applies across the two sites of Cottam Lane and New Hall Lane, so statistics and clinical performance indicators quoted in this report apply to both provider locations.

The average life expectancy of the practice population is slightly below the local and national averages (81 years for females, compared to the local average of 82 and national average of 83 years, 77 years for males, compared to the local average of 78 and national average of 79 years).

The age distribution of the practice's patient population is broadly in line with local averages. However, the practice does cater for a slightly higher percentage of patients under the age of 18 years (24.2% compared to the local average of 21% and national average of 20.7%) and a slightly lower proportion of patients over the age of 65 years (13.4% compared to the local average of 16.2% and national average of 17.1%). The proportion of patients who experience a long standing health condition is slightly below the local and national average (51.2%, compared to the local average of 53.9% and national average of 54%).

Information published by Public Health England rates the level of deprivation within the practice population group as four on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by three GP partners (two female and one male), three female salaried GPs and four long term locum GPs (three male, one female). The practice also employs a clinical nurse specialist, a clinical pharmacist, five practice nurses and four health care assistants. Clinical staff are supported by a practice manager, deputy practice manager, medicines management coordinator and a team of reception and administration staff.

The practice trains registrar doctors, offers placements for foundation year doctors and trains medical undergraduate students from the University of Manchester.

Detailed findings

The practice is open between 8am and 6.30pm Monday to Friday, and between 8am and 11am on a Saturday morning for extended hours appointments. Surgeries are offered between 9am and 12.30 each morning and 2pm until 5.40pm each afternoon from Monday to Friday, while Saturday morning appointments are offered between 8am until 10.50am.

Outside normal surgery hours, patients are advised to contact the out of hour's service by dialling 111, offered locally by the provider Preston Primary Care.

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 November 2016. During our visit we:

- Spoke with a range of staff including GPs, clinical nurse specialist, two practice nurses, two health care assistants, the practice manager and deputy practice manager, reception and administration staff and also spoke with patients who used the service.

- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. The practice had identified and investigated 11 significant events in the previous 12 months.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and evidence that these were discussed at staff meetings and shared electronically with the broader team. We saw evidence that lessons were shared and action was taken to improve safety in the practice. Staff were able to discuss the outcomes of recent significant event analyses with the inspection team in detail. For example, following a recent near-miss around the management of a home visit request, we saw that the incident had been written up with learning outcomes clearly identified and discussed at a team meeting. The analysis had resulted in the practice's home visit policy being updated to reflect modifications to how home visit requests were managed and recorded; patients were notified of an approximate visit time and an audit process introduced to ensure all visits had been allocated to a clinician by the end of the day. Reception staff were able to discuss these changes to protocol with the inspection team.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GPs was the safeguarding lead for the practice. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults. GPs were trained to child protection or child safeguarding level three. While the practice nurses had received training to safeguarding children level three also, we did note that the health care assistants had only attained level one of this training topic at the time of our inspection. The practice manager informed us they planned to ensure the health care assistants were trained to child safeguarding level three imminently following the inspection. Published guidance would recommend HCAs be trained to level two for child safeguarding, so the practice intention would be over and above expected requirements.
- A notice in consultation and waiting rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead and was booked onto further training in this area two days after the inspection visit to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat

Are services safe?

prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction (PSD) from a prescriber (PGDs and PSDs are written instructions for the administration of medicines to either groups of patients or individual patients).

- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- We reviewed the practice's procedures around managing incoming mail, as a protocol had been drawn up detailing certain documents that the GPs felt they did not need to routinely have sight of. We found during the visit that admin staff were not following the protocol document the inspection team had been provided with; for example the admin staff informed us that correspondence relating to retinal screening or attendance at accident and emergency by a patient over the age of 11 (amongst others) that did not detail any medication changes or explicit GP actions for follow up did not need to be passed to a GP. However, these documents were not included on the procedure document we were originally shown. Immediately following the inspection, the practice provided us with a copy of another document dated as reviewed in October 2016 that did include these items of incoming correspondence in the list. The practice manager explained there was an overlap of two policies and only one of the two were shown to the inspection team on the day. The practice also provided evidence that a random sample of the letters not forwarded on to GPs was audited for quality control on a regular basis in order to ensure the procedure in place was working effectively. These audits demonstrated the process was effective.

Monitoring risks to patients

We saw that risks to patients were comprehensively and systematically assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with posters in the training room and one of the stair wells which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We found that the defibrillator pads stored with the device had expired five months previously. However, the practice immediately sourced replacement pads which were in date and these were in place before the inspection team had left the premises. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

Are services safe?

- The practice had plans in place to maintain business continuity in case of major incidents such as power

failure or building damage. The practice's branch premises ensured there was an alternative location for ongoing service provision should one of the buildings become unusable.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and these were discussed during the practice's clinical meetings to ensure all were aware of any updates. Staff used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits and peer reviews.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (excluding for those patients previously registered under Dr Nath's Practice) showed the practice had achieved 94.6% of the total number of points available, with a 10.3% rate of exception reporting for the clinical domains (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The local CCG average rate for exception reporting was 9.6% and national average 9.8%.

This practice was not an outlier for any QOF (or other national) clinical targets for the year 2014/15. Data from 2015/16 showed:

- Performance for diabetes related indicators was generally in line with the local and national averages. For example:
 - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 73% compared to the clinical commissioning group (CCG) and national averages of 78%.
 - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 76%, compared to the CCG average of 79% and national average of 78%.
 - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 82% compared to the CCG average of 78% and national average of 80%.
 - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 95% compared to the CCG average of 94% and national average of 95%.
 - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 92% compared to the CCG average of 84% and national average of 89%.
- Performance for mental health related indicators was variable when compared with the local and national averages. For example:
 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 88% compared to the CCG average of 89% and national average of 89%.
 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 90% compared to the CCG and national averages of 89%.
 - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 71% compared to the CCG average of 86% and national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 83% compared to the CCG average of 84% and national average of 83%.

Are services effective?

(for example, treatment is effective)

- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 71%, compared to the CCG and national averages of 76%.

There was evidence of quality improvement including clinical audit.

- We reviewed two clinical audits completed in the last year. Both of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result of an audit around new cancer diagnosis demonstrated that the practice improved its use of two week wait referral pathways for timely diagnosis of cancer (from 90% of eligible patients in 2014/15 to 100% in 2015/16) and also that there was a reduction from an average of 7 GP visits pre-referral to an average of just 1.43 GP visits before an appropriate referral was made.
- The other audit we reviewed examined the practice's management of patients with hypothyroid function (where patients have an underactive thyroid gland, meaning it does not produce enough hormones). This demonstrated that between September and October 2016 the practice improved the percentage of patients who were prescribed levothyroxine (medication to treat hypothyroidism) and had a thyroid function test carried out in the previous 12 months from 90.8% to 93.9%. However, this data included the patients from the neighbouring practice which had been recently taken over; the improvement for the patients previously registered at this practice was from 79% in September to 97% in October.

Information about patients' outcomes was used to make improvements. For example following a previously missed diagnosis of diabetes, the practice ran searches of their patient lists to identify other patients who may be at risk and invited them to attend for a review to initiate investigations. This resulted in a further 10 patients being diagnosed.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as fire safety, health and safety and confidentiality. Recently recruited staff told us how the practice had prepared individualised induction programmes for them including shadowing opportunities with colleagues and extended appointment slots for clinical staff to allow time for them to become accustomed to practice systems. All said they felt thoroughly supported through their induction.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Most staff had received an appraisal within the last 12 months. The health care assistants were slightly overdue an appraisal due to the timings of long term staff absence, but we saw that pre-appraisal questionnaires had been circulated in readiness for these meetings being completed.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

Are services effective?

(for example, treatment is effective)

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We saw that the practice routinely wrote to care homes in its catchment area on a quarterly basis to establish whether any of their patients had deprivation of liberties safeguards in place.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- We saw evidence that the process for seeking consent for procedures such as contraceptive coil fitting was monitored through patient records audits.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A podiatrist specialising in diabetic care, substance misuse support worker, physiotherapist and smoking cessation service all visited the practice premises regularly to offer appointments to the practice's patients.

The practice's uptake for the cervical screening programme was 76%, which was slightly lower than the CCG and national averages of 81%. However, the practice's exception reporting rate for this indicator was 6% lower than the local average and almost 4% lower than the national average. The practice used telephone reminders for patients who failed to attend appointments as well as alerts on the patient electronic record system to prompt clinicians to offer screens opportunistically in order to increase uptake and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were generally higher than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90.6% to 98% (CCG average range from 89.4% to 93.2%, national average range from 73.3% to 95.1%) and five year olds from 87.4% to 96.7% (CCG average range from 83.8% to 95.9% and national average range from 81.4% to 95.1%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40–74 as well as health checks for those patients aged over 75 years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 22 patient Care Quality Commission comment cards we received made positive remarks about the service experienced. Many of the cards identified that patients felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We did note that two of the cards also made reference to the occasional 'impersonal' manner of some staff.

One of the practice receptionists was the winner of the CCG's practice staff award in May 2015 in recognition that she had gone the extra mile in ensuring patients had access to the best quality healthcare. The practice manager had also been nominated for this award recognising the patient centred ethos running throughout the organisation.

We spoke with four members of the patient participation group (PPG), who were also patients at the practice as well as one other patient on the day of inspection. They also told us they were extremely satisfied with the care provided by the practice and said their dignity and privacy was respected. They highlighted that staff responded compassionately when they needed help and provided support when required. Patients we spoke to complimented the practice on managing to maintain a personal touch despite the practice increasing in size.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect, however the practice scored lower than the local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 78% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and national averages of 89%.
- 76% of patients said the GP gave them enough time compared to the CCG and national averages of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 74% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national averages of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. The patients we spoke with also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. The vast majority of patient feedback from the comment cards we received was positive in this respect and aligned with these views. However, two of the comment cards we received did not share this perspective. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, although results were generally lower than local and national averages. For example:

- 71% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 70% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.

Are services caring?

- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

The practice discussed these results with us and demonstrated how the GPs had reflected on them and were addressing the issues they felt were contributing to them. The GPs felt that the recent recruitment of a clinical pharmacist and clinical nurse specialist would help in presenting a more stable clinical workforce for patients and facilitate improved continuity of care.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 206 patients as carers (1.5% of the practice list). Written information was available to direct carers to the various avenues of support available to them and they could access health checks at the practice for their needs to be monitored.

Staff told us that if families had suffered bereavement, personalised care was offered depending on the needs of the families. This may consist of a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had recently employed two new clinical members of staff (a clinical nurse specialist and a clinical pharmacist) to broaden the skill set of the practice's clinical team. The nurse was a diabetes specialist and since coming into post in May 2016 had undertaken work to improve the diabetes control amongst this patient cohort. At the time of her appointment the practice had identified 185 patients who were at risk of having poorly controlled diabetes. By the time of our inspection the nurse had reviewed all of these patients who were not under the care of specialists at the hospital and offered lifestyle advice and changes to medication where needed.

- 37 patients had had insulin medication initiated by the nurse. Of these 37, 17 had attended for a further review after commencing the medication. 16 of these had seen a reduction in their blood sugar levels, nine of which were now within normal limits.
- The nurse had amended insulin dosage taken by 16 patients already using the medication. Six of these patients had already attended for a further review which had identified a success rate of 100% in reducing blood sugar levels. Four of the six patients were found to have blood sugar levels within the normal range.
- The nurse had also initiated 79 patients on oral medication for diabetic control. Of these, 39 patients had attended for further follow up review and 37 of these were found to have a reduced blood sugar level, with 27 within normal limits.

The nurse had also written a "starting with insulin" manual which was given to all patients being initiated on the medication. This comprehensive document included useful contact numbers, information on symptoms, blood testing regime and medication as well as advice around driving and dieting. The practice told us how they were able

to initiate a newly diagnosed patient on insulin within two weeks following the need being identified, rather than the patient having to wait six weeks or more were they to need to attend a secondary care setting for this service.

The clinical pharmacist took up the post with the practice in June 2016 and was trained as a specialist mental health pharmacist. They had begun undertaking the annual reviews for patients on the practice's mental health and dementia registers. We saw that they were able to spend longer with these patients (30 minute appointments) which facilitated building an improved rapport with this patient group. The pharmacist was trained to prescribe medicine and also had ring fenced time to run anticoagulation monitoring clinics twice per week and had specifically undertaken reviews of patients whose blood results were out of range in order to update medication to better control their condition.

Other aspects of the practice's service which we identified as being responsive to patient's needs were as follows:

- The practice offered extended hours appointments on a Saturday morning for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and those with complex health needs.
- Patients with multiple and complex needs attended for one single review appointment to deal with all their needs, rather than attended separate reviews for each condition. This minimised unnecessary trips to the practice.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as some only available privately. They were referred to other clinics for other vaccines available privately not offered in-house.
- There were disabled facilities, a hearing loop and translation services available.
- There was a lift to facilitate access to the upper floors of the premises.



Are services responsive to people's needs?

(for example, to feedback?)

- A range of electronic services were available for patients, such as the facility for booking appointments and ordering prescriptions online.
- The practice attempted to maximise attendance at appointments by sending text message reminders to patients if they had consented to this service.
- Practice staff had set up a weekly "health walk" in the local park each Thursday morning, and invited patients to attend. This promoted a healthy lifestyle as well as providing social interaction and networking opportunities for patients who otherwise may be isolated.
- An active and engaged patient participation group facilitated the collection of patient feedback to ensure that services were appropriately tailored to meet the needs of the local population.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday, and between 8am and 11am on a Saturday morning for extended hours appointments. Surgeries were offered between 9am and 12.30 each morning and 2pm until 5.40pm each afternoon from Monday to Friday, while Saturday morning appointments were offered between 8am until 10.50am. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and national average of 79%.
- 75% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and national average of 73%.

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

The practice had a system in place to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the form of summary posters describing the complaints procedures on the notice boards in the waiting areas, information leaflets available from reception as well as details outlined on the practice website.

We saw that 18 complaints had been received in the last 12 months. We looked at a sample of these and found they were satisfactorily handled, dealt with in a timely way with openness and transparency. The practice routinely documented verbal complaints as well as those received in writing. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, following identification of a trend of patient feedback relating to difficulties getting through to the practice by telephone, a system was implemented whereby at busy periods additional administration staff had their phone sets logged into the main practice line so as to better handle the volume of calls received. The members of the patient participation group we spoke to confirmed that this change had been swiftly implemented once the practice had become aware of the issue and reported it had been successful in improving telephone access.

Members of the PPG told us that anonymised summaries of complaints received were presented regularly at PPG meetings with practice staff as the practice sought patient's perspectives on whether it had handled and resolved the issues raised satisfactorily.

Are services well-led?

Good 

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

Our findings

Vision and strategy

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

- The practice had a mission statement which was displayed on the practice website and staff knew and understood the values.
- The practice was able to outline its strategy verbally to us during the inspection. While a short term supporting business plan document had been produced which reflected the vision and values and included general areas of focus, this was for the time period of the next financial year only and did not specify specific actions or timescales by which these would be achieved.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. We saw that policy control systems were in place to ensure they were reviewed regularly and their contents kept up to date.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were systematic and comprehensive arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people appropriate support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. The practice manager told us that a whole staff away day was planned for the upcoming year.
- Staff said they felt respected, valued and supported, particularly by the partners and management in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met

Are services well-led?

Good 

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

regularly (every three to six months), carried out patient surveys and submitted proposals for improvements to the practice management team. We were told how GPs often attended the PPG meetings as well as management and other non-clinical staff. Members of the PPG told us how the group had in partnership with the practice organised fund raising events to raise money both for charity as well as to purchase additional equipment for the practice, such as for minor surgery as well as toys for the waiting area. Members of the group fed back to us how they felt the practice was highly responsive to patient feedback and gave the example of patients finding the prescription system confusing. They told us the practice swiftly produced posters for display in the waiting areas to clarify the system.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, and that the GPs and management were very receptive to any issues raised. Staff told us they felt involved and engaged to improve how the practice was run. Staff told us for example that they had suggested to the practice management that systems for the anticoagulation clinics be altered in order to streamline the process for patients and staff. Patients had been requesting Warfarin (anticoagulation medication) from the reception desk following an appointment. Staff suggested that these requests could be dealt within the consultation with the clinician to save the patients and receptionists time. We were told that this change had been swiftly put in place and had been well received by both patients and staff.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had engaged in recruitment activity to strengthen the clinical team and add to the knowledge and skill set so as to improve the care offered to patients. The practice had secured funding for the clinical pharmacist's post which had allowed it to further tailor services offered to meet the needs of the patients. The practice had also supported the newly recruited clinical nurse specialist in her training to become an advanced nurse practitioner. She was due to complete this training in December 2016.

The practice engaged in other local pilot schemes, such as the Lancashire Patient Record Exchange Service (LPRES) scheme. This was a trial of an electronic record sharing system which facilitated patient information held by different health and social care organisations, on disparate computer systems being shared between organisations quickly. The practice was using the system and staff attended regular steering group meetings to feedback and support the further development of the system.

Meetings were held with other practices in the locality to facilitate collaborative working. The GPs also held roles in the local area that allowed the broader sharing of learning and facilitated fresh ideas being brought back into the practice. One of the GPs was a CCG director and took the lead role in the CCG for Equality and Diversity and urgent care. Another GP partner was also on the CCG membership council, while the third GP partner was a representative for the local medical council.