

Marybone Health Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Marybone Health Centre on 11 August 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Some equipment at the practice was not in use, for example spirometry equipment and a defibrillator. Staff could not say when they would be available for use. There was no risk assessment in place to support any decision by the practice not to have a defibrillator available for use.
- 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 commented that 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 commented that they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

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

- ensure spirometry equipment used by nurses who review patients with COPD is serviced, available and ready for use.

There were areas of practice where the provider should make improvements. The provider should:

- conduct a risk assessment on the need for a defibrillator at the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. However, we found emergency equipment, for example, the defibrillator was not available for use. The spirometry equipment required by nurses when reviewing patients with COPD was not available and ready for use.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with those expected for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs, for example in relation to Caldecott principles had been identified and training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

Patients told us they were generally able to get an appointment with a GP, and when needed there was continuity of care. Patients said urgent appointments were available on the same day. The practice had good facilities and was fully accessible to patients who were wheelchair users and for parents using prams and pushchairs. 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 any action points applied to prevent the same cause for complaint arising in the future.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. 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 practice meetings. There were systems in place to monitor and improve quality and identify risk. The practice considered feedback from staff and patients, which it acted on when necessary. The practice patient participation group (PPG) was not formally established, but work continued in trying to secure representation, particularly from the student population, who made up a large proportion of the practice register. Staff had received regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice offered personalised care that met the needs of the older people in its population. We found the service offered flexibility in terms of accommodating home visits, when these were required. It was responsive to the needs of older people, and offered appointments 'on the day' for those patients who were identified as having complex needs that required more support. The practice provided opportunistic dementia screening, and used risk stratification tools to identify those older patients most at risk of unplanned hospital admission. These patients had care plans in place designed to support them and their carers, and giving key named contacts, for example their named GP or community nurses.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice nurse helped manage those patients with chronic disease and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients had 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.

Good



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. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with 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

Good



Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice recognised that students formed a large part of their patient register, being located in the city centre and accessible to students at universities in the city. The practice staff worked hard to ensure that new patients who were students found it easy to register with the practice, and were able to access services quickly. GPs encouraged all students to attend for MMR vaccination and Meningococcal C vaccination.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people. This enabled staff to encourage these patients to attend health care appointments, and ensure out of hours services were aware of who these patients were. It had carried out annual health checks for people with a learning disability and these patients had access to a named GP. The practice offered longer appointments for patients identified as needing more time with a nurse or GP, including those patients with a learning disability.

Good



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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Good



Summary of findings

What people who use the service say

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were all positive about the standard of care received. Patients commented on the helpful nature of support staff and on the quality of care provided by the long term locum GPs at the practice and the practice nurse.

In information we reviewed before our inspection, we considered the responses to the NHS England GP Patient Survey. The latest available results from this were published on 4 July 2015. The practice distributed 445 survey forms. Forty nine forms were returned, which gives a response rate of 11%.

Responses to some survey questions by patients showed the practice performed in line with or slightly better than other practices, particularly in areas that we know to be important to patients. For example, the number of patients when asked, who said they found it easy to get through to the practice by phone, was 88.5%. The average score locally for this was 75.1%, and nationally just 74.4%.

When asked, 85.8% of patients described their experience of making an appointment as 'good'. Locally the score for this was 75.4% and nationally 73.8%. When asked, 84.2% of patients would recommend the practice to someone new to the area. Locally the score for this was 79% and nationally 78%.

There were also areas covered by the survey where the practice did not score as well as other practices locally and nationally. When patients were asked if they were given enough time when they saw a GP, 82.1% said they were whilst the score locally was 89.4% and nationally 86.8%. When asked if patients thought the last time they saw a GP, the GP was good at listening to them, only 77.5% of patient said they were. The score locally was 90.2% and nationally the score was 88.6%. And when patients were asked if the GP they last saw or spoke to was good at treating them with care and concern, 71.2% of patients said they were, whilst 87.6% was the score locally and 85.1% nationally.

Areas for improvement

Action the service **MUST** take to improve

- The provider must ensure spirometry equipment used by nurses who review patients with COPD is serviced, available and ready for use.

Action the service **SHOULD** take to improve

- The provider should conduct a risk assessment on the need for a defibrillator at the practice.

Marybone Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Lead CQC Inspector and included a GP Specialist Advisor and a Practice Manager Specialist Advisor.

Background to Marybone Health Centre

Marybone Health Centre is located in Liverpool City Centre. The practice serves approximately 5,400 patients who live in and around the city centre. The practice population whilst varied, includes a significant number of patients between the age of 20-29 years of age, a large proportion of which are students. The practice register has grown year on year, and is expected to rise further when two new, purpose built student accommodation blocks open, housing approximately 1300 students.

The practice operates from a purpose built facility. This provides four consulting rooms, one treatment room, a patient reception and seating area with access to patient toilets that are suitable for use by people with impaired mobility. The office manager is located in a workspace at the back of the reception area. The practice also has a meeting room, administrative offices and staff restroom and utility area.

The practice clinical team is made up of three GP's, one male and two female. These are supported by a practice nurse and healthcare assistant. The locum GPs have been at Marybone Health Centre for a considerable period and have offered continuity of care for patients registered with the practice. The services are delivered under an Alternative Primary Medical Services (APMS) contract.

The practice is open from 8.00am to 6.30pm, Monday to Friday. An extended hours surgery is provided on Tuesday of each week, when the practice is open until 8.30pm. Out of hours services are provided by Urgent Care 24 (UC24).

From data we reviewed we could see that the provider had performed in line with expectations in key areas that are measured by the Quality Outcomes Framework (QOF). (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

All regulated activities are delivered from the address given for the practice in this report. There are no branch surgeries linked to this practice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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?

Detailed findings

- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 August 2015. During our visit we spoke with a range of staff including a GP, a practice nurse, the office manager and other support staff. We also spoke with the Medical Director and Chief Operating Officer. We were not able to speak with patients on the day of our inspection due to time constraints of the inspection team and the availability of patients late in the day, but reviewed comment cards that patients had completed, sharing their views of the service. We observed how people were being cared for and how staff helped and supported them to access the care and treatment they needed.

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting and recording significant events. When we reviewed a sample of these we saw that all significant events were recorded in a uniform manner, were reviewed and discussed following analysis and any learning from the event was shared and applied. We saw how the practice conducted an annual review of all significant events to check for any common themes. Where a change in working practice was required, this was actioned.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. Alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were received by the practice from the providers head office. We saw that these were shared with all clinicians and where patients care and treatment required review, this was done without undue delay.

Overview of safety systems and processes

Arrangements were in place to safeguard vulnerable adults and children from abuse. These reflected relevant legislation and local requirements, and policies on this were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a GP lead for safeguarding. When we made checks we saw that GPs had provided reports for safeguarding review boards as required. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

The practice provided a chaperone service for patients and a notice was displayed in the waiting room advising of this. (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).

All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS).

(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).

Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams 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 practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.

There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. Health and safety information was available to all staff on the shared drive of the practice computer system and training updates on health and safety were delivered annually. The premises were managed and maintained by NHS Property Services and the office manager was able to show a log of all checks conducted. We reviewed a copy of this year's health and safety audit for the practice. This was undertaken by staff from NHS property services. A few areas highlighted in the report still required addressing, such as a valid certificate for gas safety and remedial works to a door to enable it to be opened by those patients with disability access requirements. An action plan had been drawn up and the work was due to be addressed.

All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. However, we found the practice defibrillator was out of use. There was no risk assessment in place at the practice to support any decision not to have a defibrillator in place. Also, we found spirometry equipment provided for the nurse to assess patients with chronic obstructive pulmonary disease (COPD), was not being used due to uncertainty about calibration requirements.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording,

Are services safe?

handling, storing and security). Regular medication audits were carried out by the provider, with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

We found recruitment checks were in place for the majority of staff. We asked for additional evidence of these checks, as some documents for checks on GPs were not available on the day of our inspection. The provider was able to forward these to us following our inspection.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had oxygen on site with adult and children's masks.

All staff had access to a first aid kit and accident book. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. We noted that the plan documented how a major incident would be managed on a strategic level. However, it lacked detail with regards to business continuity management. For example, specific contingency arrangements were not identified, such as a buddy practice who the staff could refer patients to, or details of emergency accommodation arrangements were GPs would deliver services from whilst the practice was inaccessible. The provider has since amended the practice business continuity plan to address the shortcomings that were found during our inspection.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line 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 ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through audits at practice and provider level and in random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results showed 98.2% of the total number of points available had been achieved in the year 2014-15. We also noted that the rate of exception reporting had dropped year on year, from 4.8% in the year 2012-13, to 0.13%. This represents an improvement in performance. Exception reporting is used to remove patients from particular data categories or groups as they may not be suitable for a targeted treatment or health check. For example, a patient with a limited life expectancy would probably not be called for a routine health screening. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice used a range of information to manage risks and improve patient outcomes. Clinical audits were carried out to help drive improvement and evaluate outcomes for patients in relation to treatment they were receiving. We saw an audit that was conducted on referrals to secondary care, to see whether these were appropriate for patients. Again, we saw how results were shared with GPs. Antibiotic prescribing had been subject to audit recently, and focussed on whether GPs were applying a defined test to each incident of antibiotic prescribing. Higher, provider level audits are also conducted. One example we saw was an audit on the quality of note taking and recording of

patient consultations. The provider used a recognised tool of the Royal College of General Practitioners (RCGP) to undertake the audit, and reported back the findings to GPs. Feedback given tackled any poor standards of notes made by GPs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as safeguarding vulnerable adults and children. Staff had access to and made use of e-learning training modules and in-house training. The learning needs of staff were identified through a system of appraisals, meetings and reviews of staff development needs. Staff had access to training that met their learning needs and to cover the scope of their work. For GPs, this included ongoing support from the Clinical Director and support for the revalidation of GPs. (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).

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. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services. Staff worked with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred to, or after they were discharged from hospital. We were shown details of how one of the practice GPs had worked with the community mental health team and a social worker, to assess a vulnerable patient and provide more health care and community support. As a result the patient was offered more suitable accommodation and was given support from a multi-disciplinary team which helped keep them safe and upheld their welfare.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Patients' consent to care and treatment was sought 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. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. GPs at the practice were able to demonstrate how they had assessed patients capacity to consent, how this had been reviewed and how it was recorded and discussed with patients and their carers when appropriate.

Health promotion and prevention

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

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The practice health care assistant had been with the practice for over eleven years and was able to demonstrate a system of recall for patients who were due to have health checks. The practice used this system to identify those patients in need of further care, advice or treatment and were referred promptly by the healthcare assistant to the GPs or the practice nurse.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting 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. Reception staff were receptive to patients needs and were needed offered patients use of a private room to discuss any issues they felt required more privacy.

Information we reviewed about the practice showed its performance was in-line with practices locally, and in some areas slightly better than practices locally. This was reflected in comments submitted by patients on CQC comment cards. Patients commented that they were treated by caring staff who treated them with respect. Results available from the last NHS England GP Patient Survey showed:

- 88% of patients asked said they had confidence and trust in the last GP they saw compared to the CCG average of 95.9% and national average of 95.3%
- 82.1% of patients asked said the last GP they spoke to was good at giving them enough time compared to the CCG average of 89.4% and national average of 86.8%.

- 97.7% of patients asked said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91.8% and national average of 90.4%.
- 86.2% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87.5% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer support. This call was either followed by 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 worked with the local CCG to plan services and to improve outcomes for patients in the area. For example the practice worked with a Mental Health Liaison Officer (MHLO) who acted as a link between primary care and mental health services. As a result of communication between the practice and the MHLO, 93% of patients on the practice mental health register had undergone a recent health review with the GPs at the practice. The practice had direct access to named social workers and works with these to ensure more vulnerable patients receive the health care then need in a timely manner.

Access to the service

The practice offered longer appointments available for people with a learning disability and for those patients with multiple health conditions. Home visits were available for older patients and other patients whose condition made it difficult to attend the practice. Urgent access appointments were available for children and those with serious medical conditions.

The practice had toilets suitable for use by patients with limited mobility and translation services were available for patients who did not speak English as a first language. The practice was located close to a local YMCA and provided GP services to those patients using this facility. This meant that people with a status of no fixed abode could access healthcare. The practice had good working relationships with key workers based at the YMCA and were able to offer referrals to other services that patients at this facility may need access to, such as support services for patients with drug and alcohol problems.

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 information was available to help patients understand the complaints system, and a leaflet summarising this process was available in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

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 was focussed on the delivery of care and treatment that met the needs of its population. The practice delivered services that met the make up of its patient register which had considerable differences from those of other urban practices. For example, the practice served a large and still growing student population. The outskirts of the locality it served was rated as being in the top 10% of most deprived areas in the country. GPs, nurses and staff worked to ensure that services offered reflected the needs of all patients. GPs attended 'Fresher Fayres' at the universities in the city to offer education and advice to students on the Meningococcal C vaccination and MMR vaccination. The practice offered Chlamydia testing to all patients at new patient health check appointments. The practice GPs recognised the challenge of meeting the needs of a transient population, for example homeless patient using local hostels and the YMCA. Although the GPs working at the practice were long term locums, we saw that they were committed to educating patients and encouraging them to take ownership of their health conditions.

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. Policies were written and managed at a corporate level, but we saw that these were implemented at practice level and were available to all staff. Staff had good understanding of the performance of the practice and there was a programme of continuous clinical and internal audit which was used to monitor patient outcomes and to make improvements.

Leadership, openness and transparency

The GPs and the nurse at the practice had the experience, capacity and capability to run the practice and good quality

care. They prioritised safe, quality and compassionate care. Long term locum GPs provided visible leadership. The practice staff told us that GP's were approachable and took the time to listen to all members of staff. The GPs encouraged a culture of openness and honesty. The provider had recently recruited a Clinical Director who was present on the day of our inspection. The role of the Clinical Director was to provide support, leadership and mentoring to all GPs working at the practice. Feedback from the GP we spoke with on the day of our inspection, was that this was a positive addition to the leadership team.

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

The practice gathered feedback from patients in the form of the National GP Patient Survey and in the Friends and Family test. We saw how feedback was discussed at practice meetings, and where appropriate, changes were made. The practice was responsive to staff feedback. We were shown how one of the long term GPs had submitted a business case to the leaders of the organisation, on how the provision of sexual health services at the practice would benefit patients locally. As a result, the practice had supported some of the training required for this GP.

Staff told us they were well supported by management and would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Innovation

There was a focus on learning and improvement at all levels within the practice. For example, the practice team were signed up to a joint working initiative with social services. This meant concerns about elderly patients were raised and answered readily by the allocated social workers. For example, issues raised about isolation of older patients who lived on the outskirts of the practice boundary could be discussed with named professionals, who could offer support to uphold the welfare of this patient group.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>The provider is failing to comply with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Equipment for use of nurses performing spirometry was not ready and available for use.</p> <p>Regulation 15(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.