

Albion 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?

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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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection April 2015 – Good)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Albion Medical Practice on 12 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had some systems in place to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. However system to manage medicines and the system to monitor action taken in light of Medicines and Healthcare products Regulatory Authority (MHRA) required improvement.
- The practice reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patient's feedback was mixed in relation to the appointment system, however they reported that they were able to access urgent care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider must make improvements as they are in breach of regulations are:

Summary of findings

- Ensure care and treatment is provided in a safe way to patients in relation to the proper and safe management of medicines.

The areas where the provider should make improvements are:

- Ensure lessons learnt from significant events are documented and learning is shared with all appropriate staff.

- Ensure systems are in place to have oversight of vulnerable patients.
- Formalise the system for monitoring uncollected prescriptions.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The six population groups and what we found

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

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

Albion 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 expert by experience.

Background to Albion Medical Practice

Albion Medical Practice is the registered provider and provides primary care services to its registered list of approximately 9547 patients. The practice delivers commissioned services under the General Medical Services (GMS) contract and is a member of Tameside and Glossop Clinical Commissioning Group (CCG).

The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice offers direct enhanced services that include meningitis provision, the childhood

vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, minor surgery and rotavirus and shingles immunisation.

Regulated activities are delivered to the patient population from the following addresses:

1 Albion Street

Ashton-under-Lyne

OL6 6HF

The practice has a website that contains comprehensive information about what they do to support their patient population and the in-house and online services offered: www.albionmedicalpractice.co.uk

Albion Medical Practice is a training practice and had two GP trainees in post at the time of our inspection being supervised by the GP partners.

The age profile of the practice population is broadly in line with the CCG averages. Information taken from Public Health England placed the area in which the practice is located in the second most deprived (from a possible range of between 1 and 10).

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

Safety systems and processes

The practice did not have all the systems in place to ensure the safe care and treatment of patients.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. However we found that the practice did not have a formal system in place for monitoring vulnerable adults and although there was a child safeguarding register and safeguarding concerns were discussed at partner meetings and as part of multidisciplinary meetings this was not formally reviewed/monitored by the safeguarding lead.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.

- The practice in the main ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff, including temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice systems for appropriate and safe handling of medicines required improvement.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment required improvement.
- Although there was a system in place for monitoring uncollected prescriptions, this was not formalised and we found a numbers of prescriptions issued in January 2018 remained uncollected. These included

Are services safe?

prescriptions for antibiotics and thyroxine. We also found examples where patients had been issued repeat prescriptions despite being overdue medication reviews.

- We reviewed records of patients prescribed high risk medication which requires patients to be closely monitored, for example Methotrexate. We noted some patients were monitored by hospital services and therefore test results were not clearly recorded in patient's notes, however there was a system in place whereby GPs could directly access the most recent results from the hospital enabling them to safely repeat prescribe.
- The practice kept prescription stationery securely and monitored its use.
- Staff in the main prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However we noted not all actions and outcomes had been documented in relation to alerts received from the Medicines and Healthcare products Regulatory Authority (MHRA), for example the practice had initiated actions to the alert from the MHRA around Sodium Valproate, however we found not all actions had been followed through. Some patients medication continued to be prescribed despite the safety alert and there was no record of discussion about the risks having taken place with patients.
- The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Track record on safety

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.
- There were systems for reporting and investigating when things went wrong. The practice learned and in the main shared lessons and took action to improve safety in the practice. We noted however not all incidents had been reviewed and actions/learning was not always shared or minuted in a timely manner. The practice had identified this as an area for improvement and had established quarterly meetings to focus on significant events separate from the monthly clinical meetings allowing them to identify and share learning and identify trends more clearly.
- There was a system for receiving and acting on safety alerts. However we noted not all actions and outcomes had been documented in relation to alerts received from the Medicines and Healthcare products Regulatory Authority (MHRA).
- A practice business continuity plan was in place.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (01/07/2015 to 30/06/2016) was comparable to other practices in England.
- The number of antibacterial prescription items prescribed (01/07/2015 to 30/06/2016) was comparable to other practices England.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (01/07/2015 to 30/06/2016) was comparable to other practices in England.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice hosted multi-disciplinary team (MDT) meetings, care was co-ordinated and planned and reviewed for high risk and severely frail patients The MDT comprised of GPs, a social worker, district and long term conditions nurses.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice employed a team to support patients over 75 years of age with the aim of not only improving patients outcomes but also reducing unplanned hospital admissions, use of out of hours services and

accident and emergency. The scheme incorporated patients living in their own homes and those living in residential and care settings. The team consisted of a GP, nurse and a medicines management technician and who were the first point of contact for patients and their relatives and care homes. The team worked with approximately 800 patients and provided regular reviews of patients care in partnership with community teams of social care providers to enable joined up care where possible. The scheme included weekly ward rounds to designated care homes including one care home for people older people with complex care needs and advanced dementia and home visits to those housebound. Older people who were identified by the practice as potentially vulnerable or isolated were referred to the scheme for assessment. Patients were also actively reviewed following discharge from hospital.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice had a quality improvement programme in place to identify patients with long term conditions, enabling them to provide appropriate care and treatment and support patients to lead healthier lifestyles. We saw for example in a one month period the practice had increased the prevalence of patient with hypertension by 1% (124 patients) and had systems in place to regularly review the register and add patients where appropriate.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three Royal College of Physicians (RCP) questions was 71%. This was Comparable to other practices; CCG average - 76%, National average - 71%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 74% (CCG and National 78%). The practice were ranked first in the National Diabetes Audit 16/17 for Tameside & Glossop in all 8 care processes.

Are services effective?

(for example, treatment is effective)

This was achieved by holding weekly diabetic clinics run by the GP, practice nurse and podiatrist. Three GPs and two nurses had also gained additional qualifications in diabetes care and the practice was able to initiate insulin for patients enabling them to receive care and treatment in house where appropriate.

- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 97% (CCG and National 90%)
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 81% (CCG and National 83%).
- The percentage of patients with atrial fibrillation in whom stroke risk had been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) was 85% (CCG - 89%, National - 88%).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the standard target percentage of 90% or above in three areas:
 - Percentage of children aged 2 with pneumococcal conjugate booster vaccine was 93%
 - Percentage of children aged 2 with Haemophilus influenzae type b and Meningitis C booster vaccine was 91%
 - Percentage of children aged 2 with Measles, Mumps and Rubella vaccine was 94%
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 80%, in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice offered all aspects of family planning, including contraceptive implants.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice worked closely with social care and voluntary organisation to ensure a joined up approach to provide a holistic package of care.
- The practice recorded in patient's notes if they were in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had placed alerts within majority of patient's records which also indicated patients with carers; however alerts were not consistently placed in records which would enable staff to quickly identify if patients were in vulnerable circumstances for example domestic violence.

People experiencing poor mental health (including people with dementia):

- 76% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average of 84%.
- 86% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 74%; CCG 88%; national 91%). The practice provided data which showed the outcomes were now in line with the national average.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results (2016/17) were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall clinical exception reporting rate was 8%

Are services effective?

(for example, treatment is effective)

compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. Monitoring and reviewing QOF and prescribing data as part of clinical meetings and using quality evaluation and quality improvement tools to monitor outcomes for patients.
- The practice was actively involved in quality improvement activity.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway (practice 43%) was comparable to other practices in the CCG and nationally.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, the practice had an in-house Health & Wellbeing Advisor support patients with smoking, weight matters, counselling and signposting.
- The practice were aware their patient demographic meant patients were at greater risk of long term health conditions such as diabetes and hypertension. As a result they had a quality improvement plan in place to identify at risk patients and provide education, care and treatment to those patients identified as having a long term condition.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Are services effective? (for example, treatment is effective)

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The Majority (41 out of 46) of the patient Care Quality Commission comment cards we received were positive about the service experienced, with five providing mixed feedback raising concerns about waiting times and getting routine appointments. Patients described the service they received as excellent and very good. They said the staff were professional, caring and friendly. The results of the NHS Friends and Family Test indicated patients were mostly 'extremely likely' and 'likely' to recommend the practice to their friends and family.
- All of the seven patients we spoke with on the day of the inspection were positive about the care and treatment they had received and told us they were treated with dignity and respect.
- We were provided with numerous examples of staff going the extra mile for patients who included daily communication with a patient who felt lonely and isolated and staff dropping off prescriptions on their way home.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 275 surveys were sent out and 106 were returned. This represented about 1% of the practice population. The practice were in line with or below local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 81% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.

- 72% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 86%; national average - 86%.
- 89% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 88% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 86% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 76% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified (248) approximately 3% of patients as carers. We saw information for carers was readily available in the waiting area which was up to date and there was information on the practice website. The practice had an active carers champion in post and all new patient forms asked the

Are services caring?

patient if they were a carer or being looked after. The carers champion liaised with the local carers support groups and we noted a Practice Carer Awareness training certificate was displayed in the reception area.

- Staff told us that if families had experienced bereavement, the GP best known to the family contacted them. 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.

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. Results were however below local and national averages:

- 74% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.

- 70% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 73% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours and seven day access via a local hub, online services such as repeat prescription requests, advanced booking of appointments, and advice services for common ailments.
- Extended appointments were available where required and the practice provided longer appointments for holistic long term condition reviews.
- All routine prebooked appointments with a GP were 15 minutes as were appointments with an advanced nurse practitioner.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services, for example they had a GP allocated to home visits daily, a duty doctor, telephone consultations and urgent same day appointments with an advanced nurse.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice was also able to offer a full contraceptive service and minor surgery.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Vulnerable or isolated older patients were referred to the over 75s scheme for review.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment. The practice requested relevant blood tests were performed in advance to ensure all clinical information was available to complete reviews. The multi reviews were also provided for housebound patients within their own home. Consultation times were flexible to meet each patient's specific needs.
- The practice had regular contact with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment or telephone consultation when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, appointments were available with an advanced nurse practitioner, practice nurse and phlebotomist daily from 8am and GPs from 8:30am. Patients were also able to book evening and weekend appointments for patients at the local extended hours hub.
- Emergency on the day appointments were available daily with either an advanced nurse practitioner or GP.
- Patients were able to book appointment online.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Minor surgery and a full contraceptive service were also available.

People whose circumstances make them vulnerable:

Are services responsive to people's needs?

(for example, to feedback?)

- The practice a policy and procedure in place for identifying and recording in patient's records should they be in vulnerable circumstances including homeless people, travellers and those with a learning disability. We noted however there was no formal register enabling the practice to formally monitor or review those in vulnerable circumstances.
- The community drugs team held a weekly clinic at the practice and worked closely with GPs to provide shared care.
- The practice registered and provided care to people living in local hostels and supported living facilities.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients were able to access a Healthy Minds worker in practice.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients requiring urgent appointments were able to be seen on the day by either an advanced nurse practitioner or GP. Appointments could also be made for patients at the extended hours hub locally.
- Patients with the most urgent needs had their care and treatment prioritised.
- There was a duty doctor available daily as well as a visiting GP daily to provide home visits for housebound patients or those living in residential care.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages. This was supported by observations on the day of inspection and completed comment cards. 275 surveys were sent out and 106 were returned. This represented about 1% of the practice population.

- 64% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 59% of patients who responded said they could get through easily to the practice by phone; CCG average – 69%; national average - 71%.
- 76% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 82%; national average - 84%.
- 73% of patients who responded said their last appointment was convenient; CCG - 78%; national average - 81%.
- 44% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%. To improve patient experience the practice carried out an audit of appointments and amended the system to provide more on the day urgent appointments and appointments which could prebooked 48 hours in advance, as well as increasing the number of appointments which could be book online.
- The practice used a range of methods to gather patient feedback which included planned internal surveys, questionnaires and the friends and family test. We noted in the last 12 months of the 1600 responses 92% of patients would recommend the practice to friends and family.
- All seven patients we spoke with on the day of the inspection told us they had been able to access emergency appointment when required and majority had no problems accessing routine appointments.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. There were 20 written and verbal complaints received in the last year. We reviewed four complaints and found that they were satisfactorily handled in a timely way.

Are services responsive to people's needs? (for example, to feedback?)

- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities as well as an annual quality improvement plan.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. There was a strong culture of improving outcomes for patients across the practice and this was reflected in their aims and objective.
- Staff were aware of the vision, they understood the values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region.
- The practice monitored progress against delivery of the strategy and had a quality improvement programme in place.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.

- The practice focused on the needs of patients. We saw the staff, partners and PPG had a shared purpose, to deliver positive outcomes for patients and encourage self-care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals and a timetable was in place for future appraisals and midyear reviews for newly appointed staff. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice valued training and staff development both of internal staff but also mentoring and supporting trainee GPs and training staff to become health care assistants and supported nurse to become advanced practitioners.
- Clinical staff, including nurses and pharmacists, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. We noted during the practice had experience significant long term staff sickness over a six month period and speak with staff they told us everyone pulled together and worked as a team to support each other and minimise the impact on patients by providing cross cover and additional sessions.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams and speaking with staff they felt supported and enjoyed working as a team.

Are services well-led?

Good 

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

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems in the main supported good governance and management roles were clearly set out, understood and effective. However we found that the system for monitoring action taken in light of significant events were not always reviewed and documented. However the practice had identified the need to improve monitoring and share learning and had diaried in quarterly meetings to look specifically at significant events in addition to the monthly clinical meetings.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were a number of processes for managing risks, issues and performance. However we found some process were not always monitored or reviewed.

- There was an effective, process to identify, understand, monitor and address current and future risks however systems to monitor risks to patient safety needed to be more robust, for example MHRA alerts and monitoring safeguarding. The practice showed us a new system they had implemented for recording MHRA alerts and actions taken following the most recent alert to allow them to monitor appropriate action had been taken.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of incidents and complaints, we noted however not all incidents had been reviewed and actions/learning was not always shared or minuted. The practice had identified this as an area for improvement and had established quarterly meetings to focus on significant events separate from the monthly clinical meetings.

• Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Examples included a hypertension audit to identify patients at risk and where appropriate initiate treatment and an audit of antibiotic prescribing to ensure appropriate antibiotics were only being prescribed in line with guidance.

- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made included input from clinicians to understand their impact on the quality of care. The GP partners had invested in the practice to maintain effective programmes such as the over 75's scheme when funding was no longer available, they also continued to fund an in house pharmacists as they noted the positive impact they had on patient care and access to treatment.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice had a range of methods to gather patient feedback. In addition to the National GP survey data, friends and family and responding to comments on NHS choices the PPG planned to carry out satisfaction surveys with patients.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Are services well-led?

Good 

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

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was a patient participation group with approximately 100 virtual members and a core group of 12 members who were able to attend meetings with GPs and the practice manager. Speaking with one member of the PPG they told us the practice was keen to use the patients' voice as sounding board and they were encouraged to share views and ideas with the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

The practice website was well maintained and contained information about the service provided also a range of self

care and health promotion information was available with links to local and national support organisations. The practice also created a newsletter to keep patients up to date.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

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. For example:

- The continued quality improvement programme which engaged staff at all levels
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way to patients in relation to the proper and safe management of medicines.