Sheldon Medical Centre

Quality Report

194-194A Sheldon Heath Road
Birmingham
B26 2DR
Tel: 01217434444
Website: www.sheldonmedicalcentre.co.uk

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We previously inspected Sheldon Medical Centre on 10 November 2014. As a result of our inspection visit, the practice was rated as good overall with a requires improvement rating for providing safe services; the practice was rated good for providing effective, caring, responsive and well led services. A requirement notice was issued to the provider. This was because we identified a regulatory breach in relation to regulation 12, Safe care and treatment. We identified some areas where the provider must make improvements and some areas where the provider should make improvements.

We carried out an announced comprehensive inspection at Sheldon Medical Practice on 20 June 2017. This inspection was conducted to see if improvements had been made following the previous inspection in 2014. You can read the reports from our previous inspections, by selecting the 'all reports' link for Sheldon Medical Centre on our website at www.cqc.org.uk.

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

- The practice had one shared patient list across the main practice at Arran Medical Centre and the partner practice at Sheldon Medical Centre, patients could access services at both sites if they wanted to. Most patients we spoke with during our inspection were not familiar with the main practice and were not aware that they had the option to go there also.
- We saw that in most cases medicines were prescribed in line with national prescribing guidelines, however we found that in one case there was continued prescribing of a specific opiate medicine with no rationale in the patient's record.
- There were some arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, we found that previously when the practice nurse was absent from the practice a full nursing service was not provided during this period.

Summary of findings

- We found that one of the practice's emergency medicines had expired in November 2016. Although this was recorded as a significant event, there was no assurance given to indicate if the emergency medicine had been replaced. Following our inspection the provider clarified that the emergency medicine was not needed in the practice however, no formal risk assessment was provided to support how risk was managed in the absence of the emergency medicine used to treat pain.
- The practice was rated below average for most of the areas covered in the national GP patient survey published in July 2016. Although the practice had developed an action plan in response to the survey, there was no evidence to demonstrate if these changes had been effective. Results from the survey published in July 2017 were provided by the practice following our inspection. These results highlighted some improvements around accessing the service, most results for this area however remained below the local clinical commissioning group (CCG) and national averages.
- The management team explained that they encouraged a culture of openness and honesty. However based on our evidence overall, we found that sometimes there was not an open culture and staff were not always supported in the practice.
- Most clinical performance data was above average across areas such as diabetes care. However, breast and bowel cancer screening rates were below average and although some steps were being taken to improve uptake, the practice was unable to demonstrate if this had been effective.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment

The areas where the provider should make improvements are:

- Consider alternative methods to improve cancer screening rates overall.
- Consider working on areas to improve as identified from patient feedback and the national GP patient survey and assess the effectiveness of improvement as part of a continuous improvement cycle.
- Engage with patients and utilise the patient participation group so that patients are at the heart of improvement in the practice.
- Ensure that patients are informed about alternative options available to them, such as accessing services and clinical care at the main practice, Arran Medical Centre.
- Take steps to improve exception reporting for patients suffering with dementia.
- Improve the number of health reviews of patients with a learning disability.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

At our previous inspection on 10 November 2014, we rated the practice as requires improvement for providing safe services. Although we saw some improvement in relation to these specific areas when we undertook a follow up inspection on 20 June 2017, the practices rating remains as requires improvement. This is due to other issues identified with regards safe systems and processes, monitoring risks to patients and the arrangements to deal with emergencies and major incidents.

- We saw that in most cases medicines were prescribed in line with national prescribing guidelines. However, we found that in one case there was continued prescribing of a specific opiate medicine with no rationale in the patient's record.
- Although the practices vaccination fridges were fitted with alarms to alert staff if the temperatures went out of the recommended ranges, we noticed that actual temperatures were not being recorded in line with Public Health England guidance. Staff were familiar with the appropriate steps to take in the event of a break in the cold chain.
- There were some arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, we found that when the practice nurse was previously absent from the practice a full nursing service was not provided during this period.
- We found that one of the practices emergency medicines had expired in November 2016. Shortly after our inspection the practice shared records to demonstrate that they had recorded this as a significant event. However, there was no assurance given to indicate if the emergency medicine had been replaced. Following our inspection the provider clarified that the emergency medicine was not needed in the practice however, no formal risk assessment was provided to support how risk was managed in the absence of the emergency medicine used to treat pain, or signs and symptoms of arthritis.
- The GP did not carry any emergency medicines with them on home visits and risk had not been formally assessed to determine if they were needed.

Summary of findings

Are services effective?

Good

At our previous inspection on 10 November 2014, we rated the practice as good for providing effective services. The practice is still rated as good for providing effective services.

- We saw that audits were used to drive improvements in patient care and to improve systems and processes in the practice.
- Multi-disciplinary team (MDT) meetings and palliative care meetings took place on a quarterly basis. Vulnerable patients and patients with complex needs were regularly discussed during the meetings.
- We saw evidence to demonstrate that staff had received training in the Mental Capacity Act 2005 and staff we spoke with understood the relevant consent and decision-making requirements of legislation and 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, where appropriate, recorded the outcome of the assessment.

Are services caring?

Good

At our previous inspection on 10 November 2014, we rated the practice as good for providing caring services. The practice is still rated as good for providing caring services.

- We saw that staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.
- The practice was rated below average for most of the areas covered in the national GP patient survey published in July 2016. Although the practice had developed an action plan in response to the survey, there was no evidence to demonstrate if these changes had been effective.
- Patients spoke highly of the care provided by the GP and the practice nurse and receptionists were described as friendly and helpful.
- One percent of the practices patient list were carers. There was supportive information available, flu vaccinations and annual reviews to support carers.

Are services responsive to people's needs?

Requires improvement

At our previous inspection on 10 November 2014, we rated the practice as good for providing responsive services. We identified some areas that require improvement when we undertook a follow

Summary of findings

up inspection on 20 June 2017. This is due to issues identified with regards to accessing the service and responding to and meeting people's needs. The practice is now rated as requires improvement for providing responsive services.

- Members of the management team advised us that as the practice had one shared patient list across the main practice at Arran Medical Centre and the partner practice at Sheldon Medical Centre, patients could access services at both sites if they wanted to.
- Most patients we spoke with during our inspection were not aware that they had the option to go there also. Furthermore, we did not see any information in the practice or on the practice website to inform patients about this.
- Appointments could be booked over the telephone, face to face and online. Results from the national GP patient survey published in July 2016 highlighted that responses in relation to access were below local and national averages. Results from the survey published in July 2017 were provided by the practice following our inspection. These results highlighted some improvements around accessing the service, most results for this area however remained below local and national averages.
- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Are services well-led?

Requires improvement 

At our previous inspection on 10 November 2014, we rated the practice as good for providing well-led services. We identified some areas that require improvement when we undertook a follow up inspection on 20 June 2017. The practice is now rated as requires improvement for providing well-led services.

- The management team explained that they encouraged a culture of openness and honesty. However based on our evidence overall, we found that sometimes staff did not always feel supported in the practice.
- Members of the management team assured us that there was a no blame culture at the practice; however this did not reflect our overall findings from the inspection.
- Most staff we spoke with were not familiar with the vision of the practice. Some staff spoke positively about working at the practice but some members of staff also felt over worked.

Summary of findings

- Although feedback from the patient participation group (PPG) was very positive with regards to care and treatment provided, there was no evidence to demonstrate how the PPG had been involved in any improvement work or positive changes at the 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

Requires improvement

The practice is rated as requires improvement for providing safe, responsive and well led services; this affects all six population groups including for the care of older people.

- The practice offered home visits and urgent appointments for those with enhanced needs.
- Patients received continuity of care with a named GP and a structured annual review to check that their health and medicines needs were being met.
- Immunisations such as flu and shingles vaccines were also offered to patients at home, who could not attend the surgery.
- 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 and for people aged over 75.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for providing safe, responsive and well led services; this affects all six population groups including people with long-term conditions.

- We saw evidence that multidisciplinary team meetings took place on a regular basis with regular representation from other health and social care services.
- We saw that discussions took place to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment.
- Performance for overall diabetes related indicators was 99%, compared to the CCG average of 93% and national average of 89%.
- The practice had systems in place to identify and assess patients who were at high risk of admission to hospital.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for providing safe, responsive and well led services; this affects all six population groups including for the care of families, children and young people.

Summary of findings

- The practice offered urgent access appointments for children, as well as those with serious medical conditions.
- 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.
- Overall child immunisation rates for under two year olds were at 91%, compared to the national standard of 90%. Immunisation rates for five year olds were ranged from 89% to 94% compared to the CCG average of 87% to 93%.
- Data from 2015/16 showed that the practice's uptake for the cervical screening programme was 79%, compared to the CCG and national average of 81%.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for providing safe, responsive and well led services; this affects all six population groups including for the care of working age people.

- Appointments could be booked over the telephone, face to face and online. The practice offered extended hours on Monday and Tuesday evenings between 6:30pm and 7:30pm.
- Patients had access to appropriate health assessments and checks. Practice data highlighted that they identified and offered smoking cessation advice to 45% of their patients and 12% had successfully stopped smoking.
- Although some steps were being taken to improve cancer screening uptake, the practice had not assessed how effective this had been and were unable to demonstrate if this had been effective.
- For example, 2015/16 cancer data from Public Health England highlighted that breast cancer screening rates for were at 44% compared to the CCG average of 72% and national averages of 72% and bowel cancer screening rates were at 48% compared to the CCG average of 59% and national average of 57%.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for providing safe, responsive and well led services; this affects all six population groups including for the care of people whose circumstances may make them vulnerable.

Summary of findings

- There were hearing loop and translation services available.
- There were some disabled facilities in place. A notice was displayed at the front entrance to the building advising patients to call for help if they required assistance to access the building. However, there was no doorbell or clear method on how patients could call for help if needed.
- Although the practice manager had completed an equality assessment, the assessment had not considered how risk was managed in the absence of an emergency cord in the patient toilet.
- The practice had a register of patients from vulnerable groups, this included patients with a drug or alcohol dependency. These patients were frequently reviewed in the practice and 52% of their eligible patients had received a medicines review and there were further reviews planned.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for providing safe, responsive and well led services; this affects all six population groups including for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with other health and social care organisations in the case management of people experiencing poor mental health, including those with dementia.
- Data provided by the practice during our inspection highlighted that 85% of patients diagnosed with dementia had received a review and there were ongoing reviews scheduled.
- Sixty eight percent of the practices patients on the mental health registered had received a medication and care plan review, with further reviews scheduled.
- Patients with complex needs and patients experiencing poor mental health were regularly discussed during multidisciplinary team (MDT) meetings.

Summary of findings

What people who use the service say

The practice received 103 responses from the national GP patient survey published in July 2016, 363 surveys were sent out; this was a response rate of 28%. The results showed the practice was rated below local and national averages across most areas of the survey. For example:

- 46% found it easy to get through to this surgery by phone compared to the CCG average of 67% and national average of 73%.
- 85% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and national average of 85%.
- 74% described the overall experience of the practice as good compared to the CCG average of 84% and national average of 85%.
- 70% said they would recommend their GP surgery to someone who has just moved to the local area compared to the CCG average of 77% and national average of 78%.

These survey results reflected patient feedback from both the main practice at Arran Medical Centre and the partner practice at Sheldon Medical Centre; this is because the practice has one shared patient list.

We spoke with four patients on the day of our inspection including three members of the patient participation group (PPG). Patients spoke positively about the practice team and told us they were satisfied with the care provided by the practice. As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. Staff were described as caring and friendly; this also reflected the completed CQC comment cards.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment

Action the service SHOULD take to improve

The areas where the provider should make improvements are:

- Consider alternative methods to improve cancer screening rates overall.
- Consider working on areas to improve as identified from patient feedback and the national GP patient survey and assess the effectiveness of improvement as part of a continuous improvement cycle.
- Engage with patients and utilise the patient participation group so that patients are at the heart of improvement in the practice.
- Ensure that patients are informed about alternative options available to them, such as accessing services and clinical care at the main practice, Arran Medical Centre.
- Take steps to improve exception reporting for patients suffering with dementia.
- Improve the number of health reviews of patients with a learning disability.

Sheldon Medical Centre

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.

Background to Sheldon Medical Centre

Sheldon Medical Centre is based within the Sheldon area of Birmingham in the West Midlands. This is the partner practice to Arran Medical Centre, approximately four miles away in Mull Croft, Birmingham. The two practices are led by a GP partnership consisting of a female GP partner primarily based as Sheldon Medical Centre and a male GP partner based at Arran Medical Centre.

The two locations have separate CQC registrations and therefore we inspect and report on these services separately under each registration. We did not inspect Arran Medical Centre as part of this comprehensive follow up inspection, this is because Arran Medical Centre was inspected in November 2014 and was rated as Good overall and across all domains. There are approximately 5,495 patients of various ages registered and cared for across the practice. Approximately 2,700 pf these patients tend to be seen at Sheldon Medical Centre. The practice has one patient list patients can be seen by staff at both surgery sites but most staff are situated at a dedicated site and rarely work across the two practices.

As Sheldon Medical Centre was previously rated requires improvement for providing safe services, we conducted this inspection to see if improvements had been made following the previous inspection in 2014.

At Sheldon Medical Centre, the clinical team includes the GP partner and a practice nurse; there is also a qualified phlebotomist who is training to become a health care assistant at the practice. The GP partners and the practice manager form the practice management team and they are supported by a team of eight staff members who cover finance, operations, admin, reception, cleaning and secretarial duties.

Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The practice is open from 8am through to 6:30pm during weekdays and appointments run from 9am to 12:30pm and then again from 4pm to 6:30pm. The practice has a contractual agreement in place with a local urgent care provider called Badger to provide primary care cover for the practice between the hours of 8am and 9am and 12:30pm to 4pm. Extended hours are offered on Monday and Tuesday evenings between 6:30pm and 7:30pm. There are also arrangements to ensure patients received urgent medical assistance when the practice is closed during the out-of-hours period, this service is also provided by Badger.

Why we carried out this inspection

We previously inspected Sheldon Medical Centre on 10 November 2014. As a result of our inspection visit, the practice was rated as requires improvement for providing safe services. A requirement notice was issued to the provider. This was because we identified a regulatory

breach in relation to regulation 12, Safe care and treatment. We identified some areas where the provider must make improvements and some areas where the provider should make improvements.

We carried out an announced comprehensive inspection at Sheldon Medical Practice under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions, on 20 June 2017. This inspection was conducted to see if improvements had been made following the previous inspection in 2014. The inspection was also 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 provider under the Health and Social Care Act 2008 and associated regulations.

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?
- 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)

The inspection team:

- Reviewed information available to us from other organisations such as NHS England
- Reviewed information from CQC intelligent monitoring systems
- Carried out an announced inspection on 20 June 2017
- Spoke with staff and patients
- Reviewed patient survey information
- Reviewed the practices policies and procedures

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. 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.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 10 November 2014, we rated the practice as requires improvement for providing safe services as we found that actions were not always clearly recorded in relation to significant events. We also noted that the practices cold chain records did not reflect best practice guidance by Public Health England. Effective management of the cold chain is important for the safe storage and handling of vaccinations. Furthermore, there was no policy to guide staff on how to effectively manage a break in the cold chain, such as in the event of a power failure.

Although we saw some improvement in relation to these specific areas when we undertook a follow up inspection on 20 June 2017, the practices rating remains as requires improvement. This is due to other issues identified with regards safe systems and processes, monitoring risks to patients and the arrangements to deal with emergencies and major incidents.

What we found at this inspection in June 2017

Safe track record and learning

Staff we spoke with were aware of their responsibilities to raise and report concerns, incidents and near misses. There were processes in place for formally reporting incidents. During our most recent inspection we saw records of five significant event records. Records clearly outlined actions taken and lessons learnt in response to significant events. We saw minutes of practice meetings and clinical meetings which highlighted that significant events were discussed with all staff. For instance we saw that a recent significant event was recorded with regards to a medical emergency that occurred in the practice, records indicated that staff acted appropriately to manage the emergency and this was reflected on during a practice meeting.

Overview of safety systems and processes

- The practice had clearly defined and embedded systems in place to keep people safe and safeguarded from abuse. Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation. We noted that staff had access to current safeguarding information, resources for patients, policies and access to training material. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- The GP was the lead member of staff for safeguarding. They attended regular safeguarding meetings and provided reports where necessary for other agencies; we saw evidence to support this during our inspection. Staff we spoke with demonstrated that they understood their responsibilities and all had received the appropriate level of safeguarding training relevant to their role including level three training for clinicians.
- Safety and medicines alerts were disseminated by the practice manager. Additionally, the GP had also signed up to receive alerts electronically through email. There was a system in place to keep a record of alerts and action taken and we saw evidence to support this during our inspection.
- We looked at four staff files. The files showed that appropriate recruitment checks had been undertaken prior to employment such as; proof of identity, references, qualifications and registration with the appropriate professional body and Disclosure and Barring Service (DBS) checks. 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.
- Notices were displayed to advise patients that a chaperone service was available if required. Members of the reception team would usually act as chaperones. We saw that DBS checks were in place for members of staff who chaperoned and all of them had received chaperone training.
- We observed the premises to be visibly clean and tidy and we saw that cleaning specifications and completed records were in place to demonstrate that the practice and medical equipment was frequently cleaned. There was a policy in place for needle stick injuries and conversations with staff demonstrated that they knew how to act in the event of a needle stick injury. We saw calibration records to ensure that clinical equipment was checked and working properly.
- The practice nurse was the infection control lead. There was an infection prevention control protocol in place

and we saw records of completed infection control audits. We were also able to see evidence of action taken to improve. Staff had received up to date infection control training and the training was also incorporated in to the induction programme for new staff members.

- Staff had access to personal protective equipment including disposable gloves, aprons and coverings. During our inspection we found that two out of three of the practices spill kits had expired in July 2015 and October 2016. Shortly after our inspection the practice shared records to demonstrate that they had recorded this as a significant event, records highlighted that the expired spill kits had been disposed of.
- Most recently we saw that vaccinations were stored within new vaccination fridges purchased by the practice since our last inspection. Although the practice was recording minimum and maximum fridge temperatures, actual temperatures were not being recorded in line with Public Health England guidance. However, these fridges were fitted with alarms to alert staff if the temperatures went out of the recommended ranges. Temperature records also indicated that minimum and maximum temperatures had not gone out of range. Staff were familiar with the practices cold chain policy which outlined the steps for staff to take in the event of a break in the cold chain. The practice provided further copies of the vaccination fridge temperature records following our inspection. The information clarified that in line with Cold Chain policy actual temperatures were separately recorded.
- The practice used an electronic prescribing system and prescription stationery was securely stored. All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a system in place to monitor and track prescription stationery. Uncollected prescriptions were checked on a regular basis and that those exceeding a two month period were reviewed by the GP and securely disposed of where needed, with a record made on the patient record system.
- There was a system in place for the prescribing of high risk medicines. We saw that patients prescribed high risk medicines were monitored and reviewed. During our inspection we also reviewed prescribing across other areas, including the prescribing of opiates; typically prescribed for moderate to severe pain relief. We looked at a sample of cases and saw that in most cases opiates were prescribed in line with national prescribing guidelines. However, we found that in one case there was continued prescribing of a specific opiate medicine with no rationale in the patient's record.
- The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

Monitoring risks to patients

There were some arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. For instance there was a rota system in place for the non-clinical team to ensure there was enough non-clinical staff on duty.

However, during our inspection we found that the practice nurse was absent from the practice for approximately one month in 2016 and we received mixed feedback from staff with regards to how the practice managed during this period. For instance the practice manager explained that nurses from the main practice at Arran Medical Centre would be utilised in the event of the practice nurse being absent from the practice. We found that when the practice nurse was absent from the practice although nurse support was provided, this was only for specific services such as flu vaccinations and therefore a full nursing service was not provided during this period

Although members of the management team advised that patients could access nursing services approximately four miles away at Arran Medical Centre, not all patients we spoke with during our inspection were aware that they could access care at the main practice. Furthermore, we did not see any information in the patient waiting area to inform patients about this and there was no information about Arran Medical Centre on the practice leaflet. Additionally, there was a website for the main practice at Arran Medical Centre and a separate website for the partner

practice at Sheldon Medical Centre, the websites did not make reference to each practice and did not inform patients that they could access services at both practice sites.

Following our inspection, we were provided with a practice leaflet containing information about services at both Sheldon Medical Practice and Arran Medical Centre.

There was a health and safety policy and the practice had risk assessments in place to monitor fire risk and the safety of the premises. We saw records to show that regular fire alarm tests and evacuation drills had taken place. When we inspected the practice previously we found that formal risk assessments were not in place to assess specific risks associated with infection control, including legionella and the control of substances hazardous to health (COSHH).

During our most recent inspection we saw records on a legionella risk assessment and records were in place to demonstrate that actions were regularly completed to manage risk; this included regular temperature checks and temperature monitoring. We also saw COSHH risk assessments in place during our most recent inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents, for example:

- There was a system on the computers in all the treatment rooms which alerted staff to any emergency in the practice.
- When we inspected the practice in 2014, we found that there was no business continuity plan in place for major incidents such as power failure or building damage. We saw copies of a comprehensive business continuity plan during our most recent inspection. Staff were familiar with the plan and new how to access copies in and outside of the practice if needed.
- Records showed that all staff had received training in basic life support. The practice kept emergency medicines, a defibrillator and oxygen with adult and children's masks. There was a first aid kit and accident book available.
- Although we saw records to confirm that the emergency equipment and emergency medicines were regularly checked to ensure they were in date and fit for use, we found that one of the practices emergency medicines had expired in November 2016. We bought this to the attention of the management team; they explained that the medicine would be replaced as a priority. Shortly after our inspection the practice shared records to demonstrate that they had recorded this as a significant event, records highlighted that the expired medicine had been appropriately disposed of and learning shared. However, there was no assurance given to indicate if the emergency medicine had been replaced.
- Following our inspection the provider clarified that the emergency medicine was not needed in the practice and was therefore not replaced. However, no formal risk assessment was provided to support how risk was managed in the absence of the emergency medicine used to treat pain.
- The GP did not carry any emergency medicines with them on home visits and risk had not been formally assessed to determine if they were needed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 10 November 2014, we rated the practice as good for providing effective services. The practice is still rated as good for providing effective services.

What we found at this inspection in June 2017

Effective needs assessment

The practice carried out assessments and treatment 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 identify and assess patients who were at high risk of admission to hospital. This included review of discharge summaries following hospital admission to establish the reason for admission. The practice also reviewed their patient's attendances at the local Accident and Emergency departments. We saw evidence to support that adequate care plans were in place and there was an effective recall system in place for patients needing medication and general health reviews.

Management, monitoring and improving outcomes for people

The practice used the information collected for QOF and national screening programmes to monitor outcomes for patients. The practices overall QOF achievement for 2015/2016 was 99% compared to the CCG average of 96% and national average of 95%. The practices exception rate was 8% compared to the CCG average of 4% and national average of 6%. Exception reporting is used to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medicine cannot be prescribed due to a contraindication or side-effect. As Arran Medical Centre and Sheldon Medical Centre shared one patient list, this data represented the QOF achievement overall for the two practices.

- The percentage of patients with hypertension having regular blood pressure tests was 81% compared to the CCG and national average of 82%.
- Performance for mental health related indicators was 100% overall compared to the CCG average of 93% and national average of 96%. A breakdown of these indicators highlighted that the practice was below average for specific areas relating to dementia care. For example, 72% of patients diagnosed with dementia had their care plans reviewed (in a face-to-face review) in the preceding 12 months, compared to the CCG average of 85% and national average of 83%. Exception reporting was 16% for this area compared to the CCG and national average of 7%. Following our inspection the practice provided unverified data in relation to exception reporting rates as of March 2017, exception rates had reduced to 12%.
- More recent data provided by the practice highlighted that 85% of patients diagnosed with dementia had received a review and there were ongoing reviews scheduled.
- More recent data provided by the practice highlighted that where eligible, 68% of the practices patients on the mental health register had received a medicine and care plan review, with further reviews scheduled.
- Performance for overall diabetes related indicators was 99%, compared to the CCG average of 93% and national average of 89%.

We saw that audits were used to drive improvements to patient care as well to improve systems and processes in the practice. For instance, we saw records of an audit aiming to ensure that all patients prescribed a specific high risk medicine were up to date with therapy and blood monitoring checks. The first audit was conducted in November 2016, a total of 48 cases were reviewed and 11 patients were overdue a review for therapy and blood monitoring. These patients were called in to the practice for the required reviews. The audit also highlighted some inconsistencies in the information stored on the practices patient record system and the system used for blood monitoring in secondary care, as an action point clinicians strengthened their data entry process to ensure a current and accurate reflection across the two systems. The repeated audit was conducted in February 2017; this indicated that all patients on specific high risk medicines were up to date with therapy and blood monitoring reviews.

Effective staffing

- The practice had an induction programme for newly appointed members of staff that covered topics such as safeguarding, fire safety, health and safety, infection

control and confidentiality. Induction programmes were also tailored to reflect the individual. The practice had an induction pack for locum clinicians to use when working at the practice.

- The GP had a mixture of enhanced skills including sexual health and long term condition management. Clinicians were up to date with their yearly continuing professional development requirements and had been revalidated.
- Staff received annual appraisals were supported to attend training courses. We saw that the nurse attended study days for updates on immunisations and cervical screening, the practice nurse also engaged with local nurses at quarterly nurse meetings facilitated by the clinical commissioning group (CCG). A member of the non-clinical team was being supported to attend training courses in order to become a health care assistant. In addition to in-house training staff made use of e-learning training modules.

Coordinating patient care and information sharing

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital.

Multi-disciplinary team (MDT) meetings and palliative care meetings took place on a quarterly basis. Vulnerable patients and patients with complex needs were regularly discussed during the meetings. We saw that discussions took place to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment.

The practice had three patients on their palliative care register. The data provided by the practice highlighted that these patients had care plans in place and they were regularly reviewed. We saw that the practices palliative care was regularly reviewed and discussed as part of the MDT meetings to support the needs of patients and their families.

There were 28 patients on the practices learning disability register, 53% of their eligible patients had received a health review and there were further reviews planned. These patients were discussed as part of the MDT meetings to support the needs of patients and their families.

The practice had a register of patients from vulnerable groups, this included patients with a drug or alcohol dependency. These patients were regularly reviewed and discussed as part of the MDT meetings to support the needs of patients and their families. Practice data highlighted that 21 patients were on the register, these patients were frequently reviewed in the practice and 52% of their eligible patients had received a medicines review and there were further reviews planned.

Consent to care and treatment

- When we inspected the practice in 2014 we could not find any evidence to demonstrate that staff had undertaken training regarding the Mental Capacity Act 2005. Furthermore, the GP did not demonstrate a clear understanding of Gillick competencies. These competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.
- During our most recent inspection we saw evidence to demonstrate that staff had received training in the Mental Capacity Act 2005 and staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, this included the GP.
- Patients' consent to care and treatment was sought in line with legislation and guidance. 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, where appropriate, recorded the outcome of the assessment.

Supporting patients to live healthier lives

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 and for people aged over 75. Appropriate follow-ups on the outcomes of health assessments and checks were made, where

Good

Are services effective?

(for example, treatment is effective)

abnormalities or risk factors were identified. Patients who may be in need of extra support were identified and supported by the practice. Patients were also signposted to relevant services to provide additional support.

- Data provided by the practice showed that they had offered smoking cessation advice and support to 45% of their patients and 12% had successfully stopped smoking.
- The practice offered annual reviews and flu vaccinations for various population groups including patients with a long term condition, carers and patients aged 65 and over.
- Data from 2015/16 showed that the practice's uptake for the cervical screening programme was 79%, compared to the CCG and national average of 81%. The practice nurse operated an effective failsafe system for ensuring that test results had been received for every sample sent by the practice. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.
- 2015/16 cancer data from Public Health England highlighted that breast cancer screening rates for were at 44% compared to the CCG average of 72% and national averages of 72% and bowel cancer screening rates were at 48% compared to the CCG average of 59% and national average of 57%. Following our inspection the practice provided a report which demonstrated that although bowel cancer screening rates were below CCG and national averages, they had steadily increased over time; increasing from 40% in 2009/10 to 48% in 2015/16.
- Staff advised that they encouraged patients to attend national screening programmes for bowel and breast cancer screening. The practice manager explained that they were working with a breast screening and health promotion nurse from University Hospital Coventry and Warwickshire NHS Trust in order to try and improve breast cancer screening rates. We saw that strategies included actively contacting patients by telephone, letter and text message to encourage screening. Although some steps were being taken to improve uptake, the practice had not assessed how effective this had been and were unable to demonstrate if this had improved uptake. Furthermore, there was no evidence to demonstrate if the practice had recognised bowel cancer screening rates as an area for improvement and we could not see how steps had been taken to try to improve this.
- 2015/16 childhood immunisation rates for under two year olds were below national standards. For example, the Percentage of children administered with a pneumococcal conjugate booster vaccine was 86% which was slightly below the national standard of 90%. Additionally, 86% of children had received their MMR (measles, mumps and rubella vaccine) compared to the national standard of 90%. More recent data provided by the practice during our inspection showed that overall child immunisation rates for under two year olds were at 91%.
- Immunisation rates for five year olds were ranged from 89% to 94% compared to the CCG average of 87% to 93%.

Good

Are services caring?

Our findings

At our previous inspection on 10 November 2014, we rated the practice as good for providing caring services. The practice is still rated as good for providing caring services.

What we found at this inspection in June 2017

Respect, dignity, compassion and empathy

- Curtains and screens 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 and that conversations taking place in these rooms could not be overheard.
- Reception staff advised that a private area was always offered to patients who wanted to discuss sensitive issues or appeared distressed.
- We noticed that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

The practice was rated below average for most of the areas covered in the national GP patient survey published in July 2016, for example:

- 78% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 85% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 74% 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%.
- 86% patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national averages of 87%.

An action plan was developed in response to the areas identified for improvement on the national GP patient survey. Records of the action plan highlighted that the GP was working on improving communication with patients by placing for emphasis on patient involvement during consultations, making sure care plans were discussed in thorough detail and promoting patient choice. Although the practice had developed an action plan in response to the survey, there was no evidence to demonstrate if these changes had been effective. Future actions included to review appointment length with the GP when seeing patients with particular conditions, in order to identify further strategies to improve.

We spoke with four patients on the day of our inspection, including three members of the patient participation group (PPG). Patients told us they were satisfied with the care provided by the practice and that their dignity and privacy was respected. Patients spoke highly of the care provided by the GP and the practice nurse and receptionists were described as friendly and helpful. We received 14 completed CQC comment cards during our inspection. Most comment cards were positive about the care provided at the practice.

Care planning and involvement in decisions about care and treatment

Although during our inspection patients told us that they felt involved in decision making about the care and treatment they received, results from the national GP patient survey were below average for these areas:

- 73% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.
- 76% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.

An action plan was developed in response to the areas identified for improvement on the national GP patient survey. Records of the action plan highlighted that the GP was working on improving communication techniques during consultations.

Patient and carer support to cope emotionally with care and treatment

There were 91 patients in total on the practices register for carers; this was 1% of the practices overall list. The practice

Good

Are services caring?

offered annual reviews and flu vaccinations for anyone who was a carer. There was supportive information available to support carers. Carers were also referred to a care navigator from the local Clinical Commissioning Group (CCG) who attended the practice every Thursday to support carers, the carer navigator was also able to visit carers at home to offer support. Notices in the patient waiting room told patients how to access a support groups and organisations. Staff told us that if families had suffered bereavement, the GP contacted them and the practice also sent sympathy cards to families. This call was either followed by a consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 10 November 2014, we rated the practice as good for providing responsive services. However, we identified some areas that require improvement when we undertook a follow up inspection on 20 June 2017. This is due to issues identified with regards to accessing the service and responding to and meeting people's needs. Therefore, the practice is now rated as requires improvement for providing responsive services.

What we found at this inspection in June 2017

Responding to and meeting people's needs

There were some facilities for the disabled in place, however we found that there was no emergency pull cord in the patient toilet. Although the practice manager had completed an equality assessment, the assessment had not considered how risk was managed in the absence of an emergency cord. We saw that a notice was displayed at the front entrance to the building, advising patients to call for help if needed. However there was clear method on how patients could call for help or assistance if needed, for instance if a patient was in a wheelchair.

Practice services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example:

- There were longer appointments available at flexible times for people with a learning disability, for carers and for patients experiencing poor mental health. Urgent access appointments were available for children and those with serious medical conditions.
- Clinical staff carried out home visits for older patients and patients who would benefit from these. Immunisations such as flu and shingles vaccines were also offered to patients at home, who could not attend the surgery.
- A phlebotomy service was available at the practice every Friday morning, for patients who needed a blood test. A community midwife clinic was available every Wednesday. The practice offered a minor surgery service as well as a range of chronic disease and health promotion clinics.
- Patients could access appointments and services in a way and at a time that suited them. Appointments could be booked over the telephone, face to face and online.
- There were hearing loop and translation services available.
- The practice offered extended hours on Monday and Tuesday evenings between 6:30pm and 7:30pm. The practice also utilised text messaging appointment reminders to remind patients of their appointments.

Access to the service

The practice was open from 8am through to 6:30pm during weekdays and appointments ran from 9am to 12:30pm and then again from 4pm to 6:30pm. The practice had a contractual agreement in place with a local urgent care provider called Badger to provide primary care cover for the practice between the hours of 8am and 9am and 12:30pm to 4pm. Extended hours were offered on Monday and Tuesday evenings between 6:30pm and 7:30pm. Pre-bookable appointments could be booked up four weeks in advance and urgent appointments were also available for people that needed them.

Members of the management team advised that as the practice had one shared patient list across the main practice at Arran Medical Centre and the partner practice at Sheldon Medical Centre, patients could access services at both sites if they wanted to. This included access to a male GP at Arran Medical Centre, as the GP and nurse at Sheldon Medical Centre were female. However, most patients we spoke with during our inspection were not familiar with the main practice and were not aware that they had the option to go there also. Furthermore, we did not see any information in the practice or on the practice website to inform patients about this. Following our inspection, we were provided with a practice leaflet containing information about services at both Sheldon Medical Practice and Arran Medical Centre.

The patients we spoke with during our inspection and the completed comment cards gave positive feedback with regards to the service provided. Most of the comment cards highlighted that appointments were available when needed and that patients never felt rushed during consultations.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey published in July 2016 highlighted that responses in relation to access were below local and national averages, for example:

- 46% found it easy to get through to this surgery by phone compared to the CCG average of 67% and national average of 73%.
- 66% patients described their experience of making an appointment as good compared to the CCG average of 70% and national average of 73%.
- 63% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 60% of patients usually waited 15 minutes or less after their appointment time to be seen compared with the CCG average of 63% and national averages of 65%.
- 49% of patients felt they did not normally have to wait too long to be seen compared with the CCG average of 57% and national average of 58%.

An action plan was developed in response to the areas identified for improvement on the national GP patient survey. Records of the action plan highlighted that the practice was planning to recruit two more staff members to help manage the phone lines, particularly during busy periods. The practice manager also highlighted that the practice were considering installing additional telephone lines or moving telephone providers in the future to help with telephone access.

Following our inspection, the practice provided more recent survey results from the national GP patient survey published in July 2017. These survey results were published shortly after our inspection took place. The practice received 111 responses from the national GP patient survey published in July 2017, 388 surveys were sent out; this was a response rate of 29%.

The practice highlighted that improvements had been in most areas of the survey in terms of providing a responsive service, for example:

- 49% found it easy to get through to this surgery by phone compared to the CCG average of 64% and national average of 71%.
- 68% patients described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 55% of patients usually waited 15 minutes or less after their appointment time to be seen compared with the CCG and national averages of 64%.
- 61% of patients felt they did not normally have to wait too long to be seen compared with the CCG average of 59% and national average of 58%.

We noted that although some of these areas were below CCG and national averages, improvements were made with regards to accessing the practice by telephone and for making appointments. Satisfaction rates had also increased with regards to opening times.

Listening and learning from concerns and complaints

There was a designated responsible person who handled all complaints in the practice. The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Patients were informed that the practice had a complaints policy which was in line with NHS requirements. The practice leaflet also guided patients to contact the practice manager to discuss complaints.

The practice had records of five complaints that had occurred since April 2016; these included verbal and written complaints. Records demonstrated that complaints were satisfactorily handled. Minutes of practice meetings indicated that staff shared learning and monitored themes from complaints during the meetings.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 10 November 2014, we rated the practice as good for providing well-led services. However, we identified some areas that require improvement when we undertook a follow up inspection on 20 June 2017. This is due to issues identified with regards to the vision and strategy of the practice, as well as leadership, openness and transparency. We also identified areas for improvement with regards to seeking and acting on feedback from patients, the public and staff. Therefore, the practice is now rated as requires improvement for providing well-led services.

What we found at this inspection in June 2017

Vision and strategy

Sheldon Medical Centre was a partner practice of Arran Medical Centre, with a female GP partner primarily based as Sheldon Medical Centre and a male GP partner based at Arran Medical Centre.

Although the practices formed one GP partnership, we found that they generally operated as separate services. For instance, although they had one shared patient list, patients were usually seen in their chosen practice and did not move between practice sites. Furthermore, we found that the partnership did not effectively promote the option for patients to access services at both practices. Members of the management team explained that occasionally clinicians would work across both practice sites, for instance to provide clinical cover if needed. As Arran Medical Centre and Sheldon Medical Centre shared one patient list, most of the data we looked at during our inspection represented the two practices as a whole, such as quality outcomes framework (QOF) and national GP Patient survey data. Therefore, we could not always see how the practice was performing individually.

One of the GP partners was also a GP trainer and a tutor for Birmingham University; they regularly provided training and supervision to trainee doctors and nurses based at Arran Medical Centre. Although we saw that staff meetings took place, we found that these were usually specific to each practice group.

The practice had a set of aims and objectives which included an aim to provide high quality, safe and effective services to patients. The practice ethos was based on mutual respect, holistic care, and continuity of care, learning and training. However, we received mixed feedback from staff across the practice when we discussed the practice ethos and culture. For instance most staff we spoke with were not familiar with the vision of the practice. Some staff spoke positively about working at the practice but some members of staff also felt over worked.

Governance arrangements

- Staff across the practice had key roles in monitoring and improving outcomes for patients.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Practice specific policies were implemented and regularly reviewed. Policies and documented protocols were well organised and available as hard copies and also on the practices intranet system.
- The practice had a formal programme of practice meetings; these took place every one to three months. We saw that these were governed by minutes and items such as patient feedback and significant events were discussed in these meetings. Staff explained that they also completed informal briefings and team catch ups on a regular basis, in between formal practice meetings.

Leadership, openness and transparency

The GP and the practice manager formed the management team at the practice. The management team explained that they encouraged a culture of openness and honesty. However based on our evidence overall, we found that staff were not always supported in the practice. Members of the management team assured us that there was a no blame culture at the practice; however this did not reflect our overall findings from the inspection.

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

The practice had a patient participation group (PPG). We spoke with three members of the PPG during our inspection. Feedback indicated that meetings had been infrequent but had recently started to improve; we saw that a member of the reception team was helping to lead on facilitating the PPG meetings. Conversations with staff and the PPG indicated that the practice was trying to engage more with the PPG and encourage more members to join. We saw posters on display to support this during our inspection. Feedback from the PPG was very positive with

Are services well-led?

Requires improvement

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

regards to care and treatment provided. The practice had recently developed an in-house patient survey as a way of gathering more feedback on patient experiences and to identify areas for improvement. The practice was in the process of collating the completed surveys and completing an analysis.

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 Although we saw that in most cases prescribing reflected national prescribing guidelines, we found that in one case there was continued prescribing of a specific opiate medicine with no rationale in the patient's record. The practice did not have effective arrangements in place to deal with medical emergencies. We found that one of the practices emergency medicines used to treat pain, or signs and symptoms of arthritis had expired in November 2016. The GP did not carry any emergency medicines with them on home visits and risk had not been formally assessed to determine if they were needed, and to assess how risk would be effectively managed in the absence of emergency medicines during home visits.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Risk was not effectively assessed in the absence of an emergency pull cord in the patient toilet and in relation to wheelchair users who may need to access the practice.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

We found that when the practice nurse was absent from the practice for approximately one month in 2016 although nurse support was provided, this was only for specific services such as flu vaccinations and a full nursing service was not provided during this period.

Based on our evidence overall, we found that there was not always an open culture and staff were not always supported in the practice. Most staff we spoke with were not familiar with the vision of the practice. Some members of staff also felt over worked.