Poverest Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Areas for improvement 9

Detailed findings from this inspection

Our inspection team 10

Background to Poverest Medical Centre 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Action we have told the provider to take 27

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Poverest Medical Centre on 26 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, caring and responsive services. It required improvement for providing care to people whose circumstances may make them vulnerable and for providing effective services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Ensure that patients with learning disabilities have their needs assessed, have comprehensive care plans in place and receive annual physical health checks.

In addition, the provider should:

Summary of findings

- Improve systems for recording and reviewing significant events and other incidents in order to identify common themes and improvements which could be made.
- Improve the provision of care planning for patients diagnosed with dementia.

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?

Good

The practice is rated as good for providing safe services. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Staff understood their responsibilities to raise concerns and report adverse incidents. Incidents were reviewed and actions to prevent recurrence were communicated to staff to support improvement. The practice had identified a need to further improve the recording and monitoring of serious adverse events. Further improvements could be made by reviewing serious events for common themes in order to identify any additional actions which could be taken to keep patients safe.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. The practice worked effectively with the local Clinical Commissioning Group to improve their referral and prescribing patterns when they identified any concerning issues.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

The practice had effective systems in place to promote health through the use of screening programmes and the provision of healthy lifestyle advice.

Some patients with complex needs, such as those with mental health issues, had care plans in place to ensure that clinical staff understood their needs and the level of support that was required. However, over half of the patients registered at the practice with dementia did not have a care plan in place. Additionally, patients with learning disabilities had no care plans in place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and

Summary of findings

respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also observed staff treating patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

The feedback we received from patients was that they were mainly satisfied with the appointments system and their access to the GPs. However, some evidence suggested that patients were dissatisfied with waiting times and were not always able to see their GP of choice. The practice manager had recently installed equipment which would be used to produce audits of waiting times in the future in order to understand at what times during the week the problems occurred with a view to rectifying the problems.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice works closely with a local care home for the elderly; one of the GPs visited the care home weekly to check on any concerns relating to patients.

There were care plans in place for elderly people who were at risk of hospital admittance and these patients were given a telephone number to ring so that they could speak to a clinician quickly about any concerns.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice held multidisciplinary team meetings with other providers to enable patients with complex needs to receive a co-ordinated package of care.

Patients with long-term conditions had a named GP and were invited for regular health checks and reviews to ensure their needs. The practice monitored their performance in relation to completing health checks and reviews. They had identified some areas where they performed less well, for example, in completing some of the routine health checks for people with diabetes. The practice offered a diabetes clinic twice a week and was working towards improving their performance in this area.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Appointments were available outside of school hours and the premises were suitable for children and babies. There were weekly antenatal and postnatal clinics with a GP or midwife.

Summary of findings

Young people were offered Chlamydia screening opportunistically. The practice had received performance feedback on their use of this service indicating they were issuing Chlamydia screening kits appropriately and that they were being used effectively.

The practice population included a traveller community meaning that there was a relatively larger number of families moving in and out of the area. Immunisation rates sometimes reflected this movement and some immunisation rates were relatively low. The practice worked with local health visitors to provide information about the importance of childhood immunisations and had good systems in place for arranging interpreting services for families whose first language was not English.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered later opening hours on Tuesdays and was open on Saturday mornings to support people outside of normal working hours. The practice was also proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. One of the GP partners took the lead in co-ordinating any safeguarding issues and all staff had received relevant training in identifying signs of abuse.

The practice held a register of patients living vulnerable circumstances including those with a learning disability. However, it had not carried out any annual health checks for patients with a learning disability and these patients did not have a care plan in place.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requiring improvement for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

The practice had told patients at risk of experiencing poor mental health about how to access various support groups and offered additional support directly from staff at the practice. This included offering support to people who were acting as carers to friends and relatives, as well as to those who had been recently bereaved.

87% of patients experiencing poor mental health had received an annual physical health check. Patients diagnosed with dementia had also been invited for an annual review and had care plans drawn up. However, the progress with these patients was not as complete. Only 44% of patients with dementia had a care plan in place.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection, including three members of the Patient Participation Group (PPG). Another 35 people completed Care Quality Commission comment cards which had been available to patients who visited Poverest Medical Centre in the two weeks before the inspection. The majority of the feedback from patients was positive about the care they received from both clinical and administrative staff.

Most patients told us they felt well supported and cared for by clinical staff. Staff were friendly and helpful. Their privacy and dignity was respected. Two out of the 35 comments cards made negative remarks about clinicians' ability to understand their needs and provide appropriate support. However, the six patients we spoke with on the day of the inspection told us that clinical staff had a caring and supportive attitude. They felt the level of care went well beyond what they expected from their primary care physician.

Some patients commented negatively about waiting times and ease of making appointments. However, patients were aware that urgent appointments were available on the same day, if necessary.

Patients generally found the systems for obtaining repeat prescriptions and referrals efficient. Those that needed regular check-ups were contacted to make an appointment at the right time.

Areas for improvement

Action the service MUST take to improve

- Ensure that patients with learning disabilities have their needs assessed, have comprehensive care plans in place and receive annual physical health checks.

Action the service SHOULD take to improve

- Improve systems for recording and reviewing significant events and other incidents in order to identify common themes and improvements which could made.
- Work towards improving the provision of care planning for patients diagnosed with dementia.

Poverest Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our team was led by a CQC Lead Inspector. The team also included a second CQC inspector, and a GP Specialist Advisor, who was granted the same authority to enter the practice premises as the CQC inspectors.

Background to Poverest Medical Centre

The Poverest Medical Centre is located in Orpington in the London Borough of Bromley. The practice serves approximately 9,200 people living in the local area. The local area is diverse in terms of levels of deprivation including relatively affluent and relatively deprived locations. There is also a larger than average traveller community leading to a high turnover of registered patients. People living in the area spoke a range of different languages and expressed different cultural needs.

The practice operates from a single site. It is situated in a two-storey building with seven consultation rooms and a minor surgery suite.

There are six GP partners and one salaried GP working at the practice; four are male and three are female GPs. There is also a practice manager, three practice nurses and two health care assistants. Three of the GPs carry out minor surgery on site, for example, for joint injections or skin lesions. The practice offers family planning services, including the fitting and removal of intrauterine devices (IUD). One of the GPs offers a gynaecological services clinic and visiting hospital consultants carry out minor surgery for gynaecological issues on a weekly basis. This gynaecological service is open to all patients in the local area, regardless of whether or not they are registered with the practice. There are also antenatal and postnatal clinics with a GP on Tuesday afternoons, and antenatal appointments with a midwife on a Thursday afternoon. Diabetes clinics are held on Tuesdays and Thursdays.

The practice offers appointments on the day and books appointments up to four weeks in advance. The practice has appointments 8.00am to 6.30pm on Mondays to Fridays. They also offer extended opening hours on Tuesdays from 6.30pm to 8.45pm and on Saturday mornings from 9.30am to 11.45 am. Patients are directed to call the '111' service for advice and onward referral to other primary care services when the practice is closed.

The Poverest Medical Centre is contracted by NHS England to provide Personal Medical Services (PMS). They are registered with the Care Quality Commission (CQC) to carry out the following regulated activities: Surgical procedures; Family planning; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Maternity and midwifery services.

Why we carried out this inspection

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

Detailed findings

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

How we carried out this inspection

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)

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 26 March 2015. During our visit we spoke with a range of staff. We spoke with four GPs, two practice nurses, two health care assistants who also acted as receptionists, a practice manager, and a secretary. We spoke with six patients who used the service. We also spoke with a local care home manager who worked closely with the practice. We conducted a tour of the surgery and looked at the storage of medicines and equipment. We reviewed relevant documents produced by the practice which related to patient safety and quality monitoring. We reviewed some patients' care plans and associated notes.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, the practice monitored national patient safety alerts, adverse incidents, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to escalate these to either the practice manager or one of the GP partners. There was a weekly clinical meeting where safety concerns were discussed and action plans were drawn up.

We reviewed safety records, significant event reports, complaints records and minutes of meetings where these were discussed over the past year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting and monitoring significant events and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Eight significant events had been recorded in the past year. In each case a record had been kept describing the nature of the event, staff and patients involved, the actions taken at the time and actions implemented following a review meeting with the GP partners.

Significant events were a standing item on the weekly practice meeting agenda so that events could be reviewed in a timely manner and actions put in place swiftly to prevent a recurrence. The minutes from these meetings were shared with staff via email. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt confident to do so. Patients had been given an apology and informed of the actions taken if they had been affected by something that had gone wrong, in line with practice policy.

There was no annual review of significant events to identify common themes and monitor the efficacy of strategies put in place to prevent the recurrence of events. We also noted that one complaint received in the past year could have been considered as a significant event but had not been reviewed in this way. Our review of the eight event records showed that three of these related to prescription errors in a six-month period during 2014. An overall review meeting may have identified this as a theme which needed particular attention.

The practice manager and GP partners told us they felt they could further improve their recording and monitoring of incidents and events. For example, the practice had held a clinical meeting in March 2015 to discuss the definition of a significant event, including the need to report near misses or no harm events. The practice manager had reinforced the need to use standardised forms which could be sent to them for monitoring purposes.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the weekly clinical meetings, and administrative staff were invited to attend if the practice's response to the alert would affect their working practices.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Clinical staff had Level three training in the protection of children and administrative staff had received Level one training. All of the clinical staff had attended a half day training course in the protection of vulnerable adults in January 2015.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal working hours. Staff cited examples of when they had escalated concerns to the practice manager or GPs.

The practice had appointed one of the GP partners as the safeguarding lead for the practice who took responsibility for working with vulnerable adults and children. The lead GP knew which children and adults were at risk, took steps to monitor this risk and to reduce it wherever possible. For example, the GP worked with the local health visitor to

monitor and protect vulnerable children. They held regular meetings to discuss specific cases. A multi-disciplinary safeguarding meeting was held on a quarterly basis to review individual cases. The last meeting had taken place in February 2015.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone and had relevant background checks with the Disclosure and Barring Service (DBS).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff we spoke with were aware of this policy and could demonstrate what needed to be done to store and monitor medicines correctly.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice responded to prescribing alerts and other advice on prescribing from NHS England and the local Clinical Commissioning Group (CCG). Staff showed us how this advice was disseminated via email throughout the practice. They cited recent examples of advice received and referred to discussing these at clinical meetings, which were held each week on a Friday. For example, a recent alert about the prescribing of some medicines for the treatment of neuropathic pain had been discussed in March 2015.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of signed directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice. We observed that prescriptions were stored securely on the premises and were not accessible by members of the public.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection control policy which had last been reviewed in August 2014. The policy specified that one of the GP partners was the lead for infection control. The responsibility was also shared with one of the nurses, and with the practice manager. The nurse maintained the cleanliness of clinical equipment and the practice manager was responsible for all supplies of protective equipment and cleaning products, and for managing domestic staff and waste contracts. Not all of the staff were aware of these governance arrangements.

However, all staff had received induction training about infection control specific to their role and received annual updates. They could all describe actions they took, such as wearing personal protective equipment (PPE) including disposable gloves and aprons. For example, reception staff knew that they needed to wear gloves when they were receiving samples from patients. We observed PPE were supplied and available to use throughout the practice.

There were arrangements in place for the safe disposal of medical waste. For example, there were colour-coded waste and sharps bins in all of the consulting rooms.

Good

Are services safe?

We saw evidence that infection control audits had been carried out by the practice for each of the last three years. The most recent audit had been carried out in February 2015 by an external representative from the public health service at Bromley local authority. They had found that the practice had a high standard of cleanliness and good processes in place for the prevention of infection. They made some recommendations, for example, in relation to how to clean the ear syringe equipment. We saw evidence that the practice had responded to this by finding the manufacturer's instructions on how to maintain this equipment to the best possible standards.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice had carried out a legionella risk assessment in October 2014. The practice manager tested the temperature of the water on a monthly basis and kept a record of this to monitor for any risks.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of November 2014. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer had been checked in March 2015.

Staffing and recruitment

There was a very low rate of staff turnover at this practice with only one new member of staff recruited in the past two years. Records for this member of staff showed that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The service occasionally used locum GPs during the summer holidays. The practice manager told us they had an arrangement with a regular locum who they had used before for this purpose. There was an induction pack for the locum GP to refer to covering key topics including, for example, referral forms and local sample testing arrangements.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

There were systems in place to protect the confidentiality of patient records. Written records were all stored in locked cabinets near the receptionists work stations on the ground floor or upstairs in an area that was behind a key-coded door. Staff had received training in information governance and could describe the measures in place to protect patient confidentiality.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in February 2015. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency) located in the reception area. An emergency trolley was situated in one of the nurse's rooms and this held oxygen and emergency medicines for the treatment of cardiac arrest, anaphylaxis, asthma and hypoglycaemia. Each consulting room also contained its

Good

Are services safe?

own anaphylaxis kit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff all knew the location of the emergency equipment and records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been recently reviewed (December 2014) in conjunction with another local practice to assess the possibility of sharing of premises in the event of an emergency. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in October 2014 and carried out checks of fire equipment, such as extinguishers, in April 2014. Actions had been taken to ensure that fire safety was maintained. For example, the checks of the fire extinguishers had led to the purchase of a new extinguisher. Records showed that staff were up to date with fire training. Regular fire drills were carried out with the last one having taken place in January 2015.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, dermatology, gynaecology and musculoskeletal disorders. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice was working with these patients to help prevent unplanned emergency hospital admissions. For example, care plans were reviewed every three months, or following discharge from hospital, to identify what additional support or changes in treatment might be required.

The practice had been visited by a pharmacist representative from the CCG in November 2014 to discuss their performance in relation to patterns of prescribing a range of medicines such as antibiotics, hypnotics, sedatives and anti-psychotics. The practice showed us their written action plan in response to this information. For example, they had agreed to more closely monitor their antibiotic prescribing to bring them in line with the local averages.

Representatives from the CCG had also visited the practice in December 2014 to discuss the practice's referral rates compared to others in the local area. This had shown, for example, that referral for dermatology issues was somewhat higher than average. The lead GP for dermatology had reviewed referring practices with the other GPs, had identified why GPs were making higher levels of referrals and provided additional training and support to rectify this issue.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us a range of clinical audits that had been undertaken in the past year. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. In one example we saw that the practice had carried out an audit in August 2013 of emergency service use amongst patients with a view to reducing overuse. The practice identified 35 patients with the highest levels of co-morbidities and medicines use. They offered these patients an initial home visit to develop a self-management plan, carry out a medicines review, and offer personalised contact when they needed help. They monitored the number of contacts with emergency services in the six months before and after this assessment. They showed that in all but one case the number of emergency service contacts was reduced. The re-audit carried out in October 2014 assessed any long-term effects of the intervention and concluded that the effect had been maintained. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice

had identified the areas where they performed less well in the QOF and discussed these at the weekly clinical meetings. For example, the practice had noted that some of the targets for people with diabetes had not been met. 76% of people with diabetes had received a flu vaccine and the QOF target was 95%. We saw that the practice had provided diabetic patients with a letter containing information about the need to have the flu vaccine in an effort to increase uptake. Both the lead GP for diabetes and specialist practice nurse were providing dedicated diabetes clinics every week in an effort to improve monitoring and outcomes for diabetic patients.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Medicines alerts were disseminated by the practice manager via email and these were discussed at the weekly clinical meetings. We saw that the practice carried out audits in response to information about certain medicines. For example, the practice nurse had recently carried out an audit of the use of a new hypoglycaemic agent in diabetic patients to monitor for any improvements in outcomes and side effects.

The practice had achieved and implemented the gold standards framework for end-of-life care. It had a palliative care register and had regular internal as well as multi-disciplinary meetings to discuss the care and support needs of patients and their families. We saw that the multi-disciplinary 'gold standards' meetings were held quarterly with the next one set for 27th March 2015. The patients we spoke with who had looked after relatives at the end of their lives commented positively about the support they and their relatives had received from the practice. This showed that the strategies in place to support people at the end of their life had been effective.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were generally comparable to other services in the area. The practice had implemented additional peer education and training where they had identified they were performing less well, for example in relation to antibiotic prescribing and dermatology referrals.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

We noted a good skill mix among the doctors. For example, three of the GPs carried out minor surgery. Different GPs also took the lead for certain illnesses or conditions. For example, one GP provided specialist care for people with diabetes; others took the lead in dermatology, gynaecology and musculoskeletal disorders.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, one of the nurses had completed prescribing courses and specialist courses in diabetes care. The health care assistants had also received relevant training in their role so that they could competently carry out health checks and give flu vaccines or B12 vitamin injections.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one of the nurses had been offered training in ophthalmology following a discussion at an appraisal meeting.

All clinical staff attended training courses provided by the local Clinical Commissioning Group (CCG) six times a year to keep their skills up to date and review new developments in legislation and guidance.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy

Requires improvement

Are services effective?

(for example, treatment is effective)

outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Test results or discharge summaries were scanned on the day they were received so that they could be sent electronically to the relevant GP for action and follow up. If the relevant GP was not working on the day the results were received there was a 'buddy' system in place to ensure the results were reviewed by another GP. The staff responsible for scanning these documents could also alert a duty doctor where they identified matters which required urgent attention. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately. This showed that the systems were working well.

The practice held quarterly multi-disciplinary team meetings to discuss the needs of complex patients, for example those with end-of-life care needs or children on the 'at risk' register. These meetings were attended by relevant health and care professionals such as health visitors, community matrons, or palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and that these meetings provided a useful forum for the sharing of important information.

The practice hosted ad hoc meetings for visiting health or care professionals to liaise with them about referrals and use of community services. For example, we saw that a new counsellor had attended a meeting in February 2015 to discuss how their service could support people with mental health needs at the practice. The practice had also held a meeting with local psychologists working on the Improving Access to Psychological Therapies (IAPT) programme in January 2015 to review how patients could access this service.

The practice worked closely with a local nursing home for elderly and frail patients. We spoke with the care manager of the home. They told us that one of the GPs visited each week to provide care to the residents of the home. They found all of the practice staff to be helpful. They said the GPs worked effectively with other services, including the local dementia mental health team and palliative care services, to ensure a high standard of co-ordinated care.

Information sharing

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

The practice used several electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made over 80% of their referrals last year through the Choose and Book system, which exceeded the target set by the local Clinical Commissioning Group. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice used a standard form, agreed with the local Clinical Commissioning Group, to record information which needed to be shared with other health professionals such as the district nurse, health visitor and community matrons. All of the health professionals involved in providing care used this form. This ensured a standard level of record keeping which enhanced the sharing of important information between services.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with told us they had received training in the MCA when it was first published in 2005. They understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. However, records showed that only 22 out of 50 patients diagnosed with dementia had a care plan in place. These care plans had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

We noted that there were no care plans in place for people with learning disabilities. However, the practice kept a register of 21 people with learning disabilities who were registered at the practice. This meant that staff were

alerted to the nature of people's disabilities when they came for appointment so that they could consider that person's decision-making capacity during their consultation.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Reception staff knew that they could book an appointment for young people and that is was up to a clinician to assess their decision-making competency.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. One of the GPs or the nurse practitioner was informed of all health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We discussed these with one of the health care assistants. They told us they had generally seen large numbers of people for these checks in the preceding years, but had experienced lower numbers this year, despite making the same number of offers to patients. Practice data showed that around 300 patients had had a health check in 2013 and around 150 in 2014. The health care assistant alerted the nurse practitioner to concerns identified during the check. The nurse discussed one issue which had arisen following a health check on the day of the inspection. This demonstrated that the system was working well at identifying issues at an early stage.

The practice kept a register of all patients with a learning disability. However, they did not yet have care plans in place for patients with a learning disability and they were not carrying out annual health checks with these patients at the time of our inspection.

The practice had identified around 480 people with diabetes and offered weekly diabetes clinics. The practice had noted that they were not performing well in terms of carrying out all of the health checks required for these patients. For example, 84% had had a foot check in the past year, which was below the QOF target of 90%. This issue had been discussed at a practice meeting in March 2015 with a view to improving performance.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 95% of patients over the age of 16 and actively offered smoking cessation clinics to these patients. The clinics were run by the health care assistants. We reviewed data submitted quarterly of four-week quit rates for smokers who attended these clinics. There was evidence the clinics were having some success with around 40% of smokers having reached the four-week smoke free target in the last quarter. The practice was also involved in a pilot project with the public health staff at the local authority to prevent the development of diabetes patients identified as at high risk. Patients at high risk had been referred to a lifestyle intervention which included referrals to local exercise and weight management programmes.

84% of eligible women had received a cervical smear test in the last five years which exceeded the target of 80% set in the QOF. The practice also offered opportunistic chlamydia screening. We reviewed information sent on a quarterly basis to the practice manager about their performance in chlamydia screening. The latest available results (July to September 2014) showed that 100% of kits issued had been returned and that 25% of cases had been positive. This showed that the practice was providing good advice about the use of the kit and were issuing them to the correct risk groups.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was generally the same or above average for the CCG at 12 months, but occasionally fell below average at 24 months. For example, uptake of the measles, mumps and rubella vaccine (MMR) at 24 months was 83% at the practice compared to a 91% average in the CCG. The GP partners were aware of this issue. There were some hard to reach and transient local populations who often declined the offer of immunisations. The practice had provided information materials describing the importance of childhood immunisations to families registered at the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (2014) and a survey of 254 patients undertaken with input from the practice's Patient Participation Group (PPG) in February 2015. The evidence from these sources showed patients were mainly satisfied with the care they received. For example, the results from the practice's own satisfaction survey showed that 91% of patients rated the care at the surgery as either 'good' or 'excellent'.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service; staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive about clinicians' ability to understand their needs and provide appropriate support. However, the six patients we spoke with on the day of the inspection praised clinical staff in terms of their caring and supportive attitude. They felt the level of care went beyond what they expected from their primary care physician.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The practice had received some recent (March 2015) negative feedback from a patient via the 'NHS choices' website regarding patient privacy. This had led the practice to review their privacy arrangements to ensure that patients could not be accidentally seen through windows during any consultation.

The practice had also put in place some systems to ensure that conversations between reception staff and patients could not be overheard. For example, the majority of the telephones used by reception staff were in a separate room from the waiting area to minimise the chances of private discussions being overheard. We also observed that practice staff were careful to log out of computers when they moved away from a work station so that patient records could not be accessed inappropriately. These measures ensured that patient confidentiality was maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a statement in the practice information leaflet about the 'zero tolerance' policy for abusive behaviour towards staff and other patients. This was also shown on the practice website. Receptionists were aware the policy stated that patients who were physically or verbally abusive could be removed from the practice list.

Care planning and involvement in decisions about care and treatment

The national GP patient survey (2014) information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the survey showed 72% of respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both of these results either matched or exceeded the average for the local area (72% and 80% respectively).

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in making decisions about their care and treatment. They felt listened to and supported by staff and were treated with dignity and respect. Patient feedback on the comment cards was also generally positive and aligned with these views.

There was evidence that patients who had long-term conditions or ongoing mental health diagnoses, were involved in agreeing suitable care plans in order to monitor and agree treatment and prevention strategies. For example, the nurse practitioner told us that she took the lead for working with people who had been diagnosed with a mental health illness. She invited people in to carry out an annual review of their needs and produced a care plan

based on this discussion. Patients kept a copy of this care plan for themselves. Practice data showed that 87% of people with mental health illnesses had had a care plan agreed and had received their annual review.

People diagnosed with dementia had also been invited for an annual review and had care plans drawn up. However, the progress with these patients was not as complete. 44% of patients had a care plan in place, although 83% had attended for an annual review.

We also noted that although the practice kept a register of all patients with a learning disability, these people did not yet have care plans in place. Practice data showed that no annual physical health checks had been carried out to identify any concerns amongst these patients. We also received some negative feedback from a patient via a comment card that clinicians did not understand or support their family in relation to attending to a relative with learning and physical disabilities.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were generally positive about the emotional support provided by the practice and rated it well in this area. For example, 88% of respondents to national GP survey (2014) said their GP was good at listening to them. The average response in the local area was 85%. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. This included information about support for carers. The practice pro-actively contacted carers to carrying out checks of their health and referred them to social services for additional support, if necessary. Some of the patients we spoke with had been carers or had been bereaved. They told us they had been well supported by all of the staff at the practice. They had received good onward referrals to other services and been contacted by staff at the practice to check on how they were doing.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice offered a range of services to meet the needs of the local population. There was a family planning service, including the fitting and removal of intrauterine devices (IUD). One of the GPs offered a gynaecological clinic and visiting hospital consultants carry out minor surgery for gynaecological issues on a weekly basis. Other GPs offered minor surgery for skin lesions and joint injections. There were also weekly diabetes, and antenatal and postnatal clinics. There was a named counsellor linked to the practice for people with mental health needs. The GPs referred people to the counsellor or the local Improving Access to Psychological Therapies (IAPT) service, as necessary.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from a patients. There was an active patient participation group (PPG). The PPG is a group of patients registered with the practice who have an interest in the services provided. We met with three representatives from the PPG during our inspection. They told us they met regularly and were consulted about issues affecting the practice. We saw minutes from a meeting where the results from the annual patient survey were discussed with the PPG in order to identify strategies for improvement. The survey had assessed patient's use of accident and emergency services together with their knowledge of what services were provided by the practice and out of hours care. The PPG had discussed actions to improve patients' understanding of these issues. For example, it was agreed that all new patients should be offered a leaflet called 'Not always A&E'.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The local area was diverse in terms of levels of deprivation including relatively affluent and relatively deprived locations. There was also a larger than average traveller community leading to a high turnover of registered patients. People living in the area spoke a range of languages and expressed different cultural needs.

The practice had put in place systems to support all people to access their services effectively. For example, the practice had access to interpreters. There was a notice in the reception area advertising this service. Reception staff told us they used this service about once a week on average with interpreters either attending the practice in person or making themselves available by phone. Information, for example, about how to make a complaint, was displayed in languages which reflected the needs of the patient population. These included information displayed in English, Polish, Chinese, and Romanian. There was a hearing loop system in the reception area to support people who used hearing aids. The local Clinical Commissioning Group was planning to offer basic courses in sign language which the health care assistants had expressed an interest in attending.

The premises and services had been adapted to meet the needs of patient with disabilities. There was a pathway leading up to the practice which was suitable for wheelchairs and prams. All of the consulting rooms were situated on the ground floor with level access for wheelchairs. The waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. An external consultant had checked that the premises were compliant with the Disability Discrimination Act (1995) in October 2014 and found that no additional actions were needed to support people to access the premises.

The practice manager carried out an annual audit to check that current access arrangements allowed all sectors of the population to use the service efficiently. The last audit had been conducted in July 2014. The results were discussed with the Patient Participation Group (PPG). The audit identified one action which was to provide automatic, computer check in for patients. This was installed in December 2014.

Access to the service

Appointments were available from 8.00am to 6.30pm on Mondays to Fridays. There were also extended opening hours on Tuesdays from 6.30pm to 8.45pm and on

Good

Are services responsive to people's needs?

(for example, to feedback?)

Saturday mornings from 9.30am to 11.45 am. Patients were directed to call the '111' service for advice and onward referral when the practice was closed. The practice's extended opening hours were useful to patients with work commitments, although we received some feedback that these appointments were often unavailable as they were fully booked.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Appointments could be made face to face, over the phone, online and via email.

The practice booked appointments up to four weeks in advance and offered appointments on the same day for more urgent matters. Patients over 65 years of age and under five were prioritised to be seen on the same day. People diagnosed with cancer or who were nearing the end of their lives were also given priority to be seen on the same day.

Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. For example, double appointments could be booked for cytology and ear syringing. Triple appointments were made for all patients who needed a care plan review and for those attending for either NHS health checks or smoking cessation advice. Home visits were made to one local care home on a specific day each week, by a named GP and to those patients who needed one.

The feedback we received from patients was that they were mainly satisfied with the appointments system and their access to the GPs. However, some people commented negatively about waiting times and felt they could not see their GP of choice. The results from the national patient survey also showed that the practice performed less well in these areas compared to others in the local area. For example 47% of patients at the practice reported being able to see their preferred GP compared to a 58% average in the local area. The survey also showed 54% of people reporting that they usually waited for 15 minutes of less after their appointment time to be seen, compared to a 64% local average. The practice manager was aware of this issue. The appointment times had not been formally monitored in the past, but there was a newly installed electronic check-in system which would be used to produce audits of waiting times. This would allow the manager to understand the problem more fully before deciding on what actions to take.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was advertised on three separate notice boards on the ground floor. There was a leaflet available about making complaints in the waiting area and the procedure was described in a practice leaflet given to all new patients when they registered. The information was also available in four different languages reflecting the needs of the local population. The complaints procedure was reviewed annually with the next review due in August 2015.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

A total of eight written complaints had been received in the last 12 months. Each complaint had been investigated and complainants had received a timely written response. Seven of the complaints had been resolved fully and one was still being investigated with support from external specialist legal advisers. There was also one historical complaint from 2011 which was being resolved in conjunction with the Ombudsman. The practice was transparent and open about all of these cases.

We saw that action plans had been put in place to prevent the recurrence of any problems identified through the investigation of complaints. For example, the practice had identified a problem with staff correctly logging the need for a home visit and checking that this had been carried out. Staff were now required to cross-check each other's work in this area and confirm that the home visit had been made.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The reception staff also kept notes of any more minor verbal complaints made to them throughout the day and passed this on to the practice manager for monitoring and review. The practice manager contacted patients to discuss these where they thought further action was necessary.

The practice did not review written complaints annually to detect themes or trends. However, lessons learned from individual complaints had been acted on. We also saw that complaints were discussed with the GP partners at the weekly clinical meeting in order to share any learning points. For example, two complaints had been reviewed at a meeting held in February 2015.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose described this vision in detail. The practice information leaflet and website advised patients to refer to a copy of the patient charter, giving details of the vision, which were displayed in the lobby area.

The practice vision and values included providing high quality primary care treatment to all members of the patient population. They aimed to promote healthy lifestyles, prevent ill health and work to secure patients' wellbeing. They placed a high value on staff skills and training and aimed to create an educational environment where good practice was shared amongst staff.

We spoke with ten members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies. For example, we reviewed the infection control and fire safety procedures. We saw that these had been recently reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, each GP was known to have specialist areas of knowledge in relation to certain conditions, such as diabetes or musculoskeletal disorders; one of the GP partners was also the named lead for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was generally performing in line with national standards. They had identified some areas for concern, for example, in relation to carrying out some health checks with diabetic patients. We saw that these concerns had been discussed at the weekly clinical meetings with a view to implementing strategies which could improve performance.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of emergency admissions in 2013 had led to the implementation of new care planning system for high risk patients. A re-audit in 2014 established that these actions had had a long-term impact on reducing the use of emergency services.

The practice had arrangements for identifying, recording and managing risks. For example, annual infection control audits were carried out and actions were put in place to minimise any risks identified during these audits.

The practice held weekly clinical meetings where governance issues could also be added to the agenda, as necessary. We reviewed a sample of minutes from these meetings for the past three months. These showed that quality, performance and risks were discussed.

Leadership, openness and transparency

There were weekly clinical meetings and meetings for administrative and reception staff approximately every six weeks. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies; for example we viewed policies related to staff recruitment, sickness absence and grievance reporting, which were in place to support staff. Staff we spoke with knew how to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through consultation with the Patient Participation Group and the use of patient surveys. The PPG was comprised of 11 representatives with a roughly equal group of men and women. The majority were from an older age and White ethnic background. The PPG had held a recruitment drive by attending flu clinics during the Autumn of 2014 with a view to increasing the diversity of its members. The PPG

Are services well-led?

Good

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

had carried out annual surveys and met every six weeks. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG.

The practice had gathered feedback from staff through the use of regular staff meetings and an annual appraisal system. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around ophthalmology and this was being arranged for them. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The staff we spoke with told us that regular appraisals took place, which included a personal development plan. Staff told us that the practice was very supportive of training. For example, all clinical staff attended training courses provided by the local Clinical Commissioning Group (CCG) six times a year.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. The practice had identified a need to improve the recording and monitoring of serious adverse events. Further improvements could be made by reviewing serious events for common themes in order to identify any additional actions which could be taken to keep patients safe.

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 9 HSCA (RA) Regulations 2014 Person-centred care We found that the practice had not taken steps to ensure that all patients were protected against the risks of receiving inappropriate or unsafe care or treatment by means of carrying out an assessment of needs and the planning and delivery of care to meet their needs in line with best practice guidance. This was because patients with learning disabilities did not have care plans in place and there was no evidence that they were receiving regular physical health checks. This was in breach of regulation 9 (1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.