3Well Ltd - Botolph Bridge

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

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Botolph Bridge Surgery on 07 May 2015 as part of our comprehensive inspection programme. 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 was also good for providing services for older patients, patients with long term conditions, patients in vulnerable circumstances, families, children and young patients, working age patients and patients experiencing poor mental health. It required improvement for providing effective services.

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

- 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.
- Urgent appointments were usually available on the day they were requested.
- The practice proactively sought feedback from patients and had a pro-active patient participation group that assisted the practice with a range of additional services for patients.
- Practice staff provided proactive and tailored services to vulnerable patients
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

We saw two areas of outstanding practice:

- The practice offered a befriending service to patients in collaboration with the PPG for those patients “who are in need of a listening ear or some encouragement”. This meant that members of both staff and the PPG would actively visit a number of patients.

Summary of findings

- The practice, via the PPG, offered monthly coffee mornings with guest speakers on specific medical subjects. They also offered a monthly luncheon club and walking groups for various abilities.

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

- Implement an effective cascading system for safety alerts and be able to evidence actions taken in response to these alerts.
- Ensure infection control leads are trained to the appropriate level, even if the role is temporary.
- Ensure complaints are dealt with in a timely manner.
- Ensure risk assessments are undertaken in sufficient depth and a comprehensive record is kept of these.
- Ensure all policies and procedures are reviewed timely and up to date. Not all policies we viewed had a review date, this included the adult safeguarding policy.

Actions the provider must take:

- Implement effective auditing and supervision of the triaging and filing of incoming patient documentation.

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. Staff understood their responsibilities to raise concerns and to report incidents and near misses. Risks to patients who used services were assessed. 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.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams. There was evidence of appraisals for all staff but some were overdue. There was a risk that important patient information might not be reviewed and acted upon by a clinician.

Are services caring?

Good

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

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. Patients said they found it easy to make an appointment with a GP, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. 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.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. Governance meetings were held regularly. The practice proactively sought feedback from patients and it had a very active patient participation group (PPG). All staff had received inductions but not all staff had received regular performance reviews.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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 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. Monthly multi-disciplinary meetings were held to identify the best ways to provide care to older people and, where appropriate, to avoid them going into hospital. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it. Older patients had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed and nursing staff took special interest in a variety of long term conditions. For those patients with the most complex needs, the practice worked with relevant health and care professionals to support patients. The practice supported patients to manage a range of long term conditions in line with best evidence based practice.

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 who were at risk, for example, vulnerable children and those under the care of the local authority (in foster or other care arrangements). Immunisation rates were generally high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors, especially around safeguarding elements.

Summary of findings

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 provided extended hours in the morning. The practice provided the option of online booking for appointments. Health promotion and screening that reflected the needs for this age group was taking place.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments when necessary. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).Clinicians provided empathetic and responsive care to patients with poor mental health. Patients experiencing poor mental health were invited to attend the practice for different physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We received 22 completed comment cards all of which were positive. We spoke with thirteen patients during our inspection, including two members from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they felt the practice was clean and that they felt that they received a good level of care. Patients we spoke with expressed mixed opinions around the appointment system in place at the practice. The practice used an appointment system where patients speak to a doctor on the phone first, upon which the doctor decides whether a face-to-face consultation is needed. The comments ranged from negative to very positive. Patients commented that the high use of locum GPs meant the practice could not always provide a very personal service as there was a lack of continuity in seeing the same GP. Patients commented that nurses delivered good clinical care acknowledged the patients' interests. The comment cards all reflected positive views, with positive comments around the caring, professional, competent and friendly approach of the staff and positive notes around the access to appointments with the appointment system that was in place. All patients we spoke with confirmed that they could always get an urgent appointment with a doctor within 48 hours. A small number of the patients we spoke with claimed to have had issues booking routine appointments. There was one mention that the online booking did not always perform to standard: a requested appointment wasn't available.

We spoke with two representatives of the PPG who were highly enthusiastic about the PPG involvement within the practice. We were told that they felt listened to by the practice and that they were critical when required in the interest of patients. They provided evidence that the practice had taken their comments and suggestions on board in the past and there were several activities that the PPG supported within the practice, for example a befriending group and coffee mornings. The PPG expressed their concerns regarding a current on going, prolonged, tender process for the ownership of the practice. The PPG commented this resulted negatively on the practice's ability to recruit new staff.

Areas for improvement

Action the service MUST take to improve

- Implement effective auditing and supervision of the triaging and filing of incoming patient documentation.

Action the service SHOULD take to improve

- Implement an effective cascading system for safety alerts and be able to evidence actions taken in response to these alerts.
- Ensure infection control leads are trained to the appropriate level, even if the role is temporary.
- Ensure complaints are dealt with in a timely manner.
- Ensure risk assessments are undertaken in sufficient depth and a comprehensive record is kept of these.
- Ensure all policies and procedures are reviewed timely and up to date. Not all policies we viewed had a review date, this included the adult safeguarding policy.

Summary of findings

Outstanding practice

- The practice offered a befriending service to patients in collaboration with the PPG for those patients "who are in need of a listening ear or some encouragement". This meant that members of both staff and the PPG would actively visit a number of patients.
- The practice, via the PPG, offered monthly coffee mornings with guest speakers on specific medical subjects. They also offered a monthly luncheon club and walking groups for various abilities.

3Well Ltd - Botolph Bridge

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to 3Well Ltd - Botolph Bridge

Botolph Bridge surgery in Woodston, Peterborough provides services centred to patients living in Woodston and the surrounding area. The surgery is located in a purpose fit building and serves a population of approximately 7000. The building is shared with other health services that serve the community. The practice is managed by an individual GP. The registered male GP is supported by one salaried male GP and locum GPs. The practice also employs two nurse practitioners, three practice nurses and two health care assistants. The clinical team is supported by a practice manager (who was on maternity leave at the time of our inspection), a managing officer, a community liaison director and a team of receptionists/administration staff. The practice had lost two practice managers in the previous six months due to retirement and bereavement. This had forced an increase and amendment of workload on the managing officer and community liaison director.

GP appointments are available every weekday between 07:30 and 18:30. The practice website clearly details how patients may obtain services out-of-hours via 111.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. 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 patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local clinical commissioning group (CCG) and the NHS England Area Team. The CCG and NHS England are both commissioners of local healthcare services. We carried out an announced inspection on 07 May 2015. During our inspection we spoke with a range of staff: reception, administrative and clinical.

We also spoke with patients who used the service and two representatives of the patient representative group PPG. We reviewed comment cards which we had left for patients and members of the public to share their views and experiences of the service. We also reviewed a range of different records held by the practice.

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, significant events recordings and national patient safety alerts as well as comments and complaints received from patients. The practice had an implemented system for reporting and responding to incidents. Staff told us that they would report concerns directly to the GP and that these would be discussed in practice meetings but that they had not come across any.

For example, a member of staff described to us, the process they would follow if a vaccine fridge was to fail. All staff we spoke with knew who the various leads were in the practice, for example for infection control or safeguarding.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. A practice meeting was held bi-weekly during which significant events were discussed. We saw minutes and evidence that the practice had reviewed actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff.

We reviewed records in respect of each of the significant events identified and recorded in the previous year. The notes included actions that had been taken in response to the incidents to reduce future recurrence and improved patient safety. We found a number of incidents had been reported including issues relating to patients' bereavements, fridge errors and external chemist errors. Staff used incident forms and sent completed forms to the practice management for processing. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, verbal feedback on test results was given by the reception team to one patient, it was highlighted that this was to be done by a clinician and a call with a clinician should have been booked. Learning took place around what information reception staff can provide patients.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated electronically or in paper form to practice staff and occasionally discussed in person. Not all staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. There was no register in place evidencing which alerts had been disseminated to whom. Minutes we reviewed from practice meetings did not contain information around safety alerts. When we queried the lack of evidence on acting on safety alerts staff acknowledged there was a gap and that they would address this. Locum GPs we spoke with were kept informed via the provision of a locum file and received safety alerts via the electronic system in the practice.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. The GP was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details; the adult safeguarding policy did not state its review date.

All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns.

Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas. 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. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after, or on child protection plans, were clearly flagged and reviewed. The lead safeguarding nurse was aware of vulnerable

children and adults and records demonstrated good liaison with partner agencies such as social services via regular meetings. We were informed that patient records were updated in line with outcomes of these meetings.

A chaperone protocol was in place and information was displayed in the waiting room. (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). Chaperone training had been undertaken by receptionists who acted as chaperones when nursing staff were unavailable. The protocol in place explained and risk assessed issues around non clinical staff acting as a chaperone. All staff that provided chaperoning had Disclosure and Barring Service (DBS) checks in place that were up to date.

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 policy and there were procedures in place 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 were able to explain the process they would follow in the case of a vaccine fridge failure.

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.

We saw records of significant events that noted the actions taken in response to a review of prescribing errors. For example, the issue of a medicine in a different dose to that prescribed had led to a verification process to ensure that all clinicians used the correct formulary. An external pharmacy was asked to closely monitor prescriptions.

The nurses and the health care assistants 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 directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff we spoke with was qualified as an independent prescriber and she received regular supervision and support in her role from the GP as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Staff we spoke with told us they manage these at medication reviews at intervals they would determine and instigate patient recalls as appropriate, ranging from three to 12 months intervals. This was done in cooperation with the local hospital and appropriate action was taken based on the results. For example, we were informed of an amendment of warfarin prescribing to a pregnant patient in which the hospital, the midwife and the practice were involved.

When we reviewed the use of disease-modifying anti-rheumatic drugs (DMARDs) the practice was unable to provide us with formal searches or audits. However they reviewed these at medication reviews to ensure safe prescribing. The repeat prescribing policy was last reviewed in 2010, but the practice did refer to a prescribing policy from the local, then called primary care trust (now clinical commissioning group), which dated back to 2011. Shortly after our inspection we were provided with a medicine management policy, originating from June 2014, that addressed prescribing matters, evidencing up-to-date protocols were place.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw cleaning records were kept in the treatment rooms by the nursing staff who kept the rooms and medical equipment clean, but the practice was unable to show us comprehensive cleaning schedules for the whole practice. The practice used an external cleaning company. We were shown a log that highlighted specific concerns, with actions taken, as recorded by the cleaners.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Infection control policies and procedures were in place, including a needle stick injury protocol.

Good

Are services safe?

The practice had a temporary lead for infection control as the normal lead was on maternity leave. The lead person that was on maternity leave had received appropriate training to act as infection control lead but the temporary lead had not undertaken further training to enable them to check adequacy of, and compliance with, the practice's infection control policy.

The staff received regular training in infection control prevention and its processes. All staff we spoke with were aware of infection control practices. Staff informed us that auditing of infection control processes was carried out and we were shown evidence that this had taken place, along with appropriate action plans that had been instigated upon any findings

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. 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. Spillage kits were available in the premises. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor operations they performed.

The practice had a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings) but this was not in line with national standards and contained very basic information only. There were no records on site that confirmed a legionella assessment had been done. Staff informed us that this had taken place and claimed the certificate was with the organisation who rented the building to the practice. No certificate was produced despite our request. However, there was a risk assessment in place around legionella testing.

We saw that the practice had arrangements and notices in place for the segregation of clinical waste at the point of generation. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

During the inspection we found records of staff immunisation against Hepatitis B. We found that this was monitored to ensure staff were protected.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Testing was last done last year and we were shown an action plan that this would be addressed again shortly after our inspection. We saw evidence (certificates) that calibration of relevant equipment was up to date.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were shown evidence of current DBS checks.

The practice had a recruitment policy and employee handbook that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body. Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs.

There was an arrangement in place for members of nursing and administrative staff to cover each other's roles. Staff we spoke with confirmed that this happened and these arrangements worked well. GP cover was provided by the lead GP, salaried GP and locums. Staff told us the frequent use of locums was not always convenient for the smooth running of internal processes, for example the processing of specimens .

Good

Are services safe?

There were always enough GP's and staff on duty to ensure patients were kept safe. Staff told us there was enough staff to maintain the smooth running of the practice. The practice was advertising for a health care assistant to provide additional capacity.

Monitoring safety and responding to risk

We spoke with both clinical and non-clinical staff about managing risks to patients and found that they had the skills to safeguard patient safety. We were given an example of how the GP had responded to behavioural concerns that had occurred in the waiting room between patients and had referred this to external services. We observed that the practice environment was organised and tidy. Safety equipment such as fire extinguishers, ventilation masks and signage were checked and sited appropriately.

Health and safety information was displayed for staff to see. The health and safety policy in place directed to a variety of other policies which were not all readily available. Hence we could not confirm that all risks to patients and staff had been identified so that they could be assessed with mitigating actions recorded to manage them. We found concerns in relation to a maternity risk assessment, this was in appropriately in situ but there was no evidence that this had been applied to a pregnant member of staff or those on maternity leave. The practice undertook basic routine checks of the building and had regular fire alarm tests of which we saw records. Annual fire evacuation drills were carried out but the fire risk assessment was overdue, the practice informed us this was highlighted to the rental agency that owned the building and were responsible for these checks.

Staff we spoke provided evidence that they were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies by explaining how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment. We saw that one member of staff dealt effectively with an emergency phone call that came in from an external healthcare professional by involving the GP. We saw from minutes that health and safety matters were discussed in training meetings at the practice, which bot clinical and non-clinical staff attended.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including a defibrillator and oxygen were available for use in the event of a medical emergency. The equipment was checked regularly to ensure it was in working condition. All staff had received up to date training in basic life support to enable them to respond appropriately in an emergency. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest and anaphylaxis. 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was explored and mitigating actions were recorded to reduce and manage the risk. Risks identified included amongst others: loss of access to the IT system, staff incapacity, loss of telephone system and loss of utilities. 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, but also details of all the staff members. Copies were held off site at locations known to the practice staff.

Update training in fire safety training was overdue, but we did see records that all staff had undertaken this in 2014 and it was planned for the future.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of monthly practice meetings where new guidelines were discussed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GP and nurses that staff completed thorough assessments of patients' needs, in line with NICE guidelines and these were reviewed when appropriate.

The lead GP had a special interest in vasectomy care. Clinical staff we spoke with were open about asking for, and providing colleagues with, advice and support. Staff told us this supported all staff to continually review and discuss best practice.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was favourable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

We were shown the process the practice used to review patients that were recently discharged from hospital and indicated for future admission avoidance. All of these were discussed in the practice and in multi-disciplinary meetings and were followed up with a care plan if deemed required.

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, patient safeguarding and medicines management. The practice achieved 94.3% of the maximum 2013/14 Quality and Outcomes Framework (QOF) results in the clinical domain against the local average of 89.3%. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed above average in comparison to the national and local figures.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included chronic obstructive pulmonary disease (COPD) medicine management, diabetic medicine management and vasectomy complications. Following the COPD and diabetes audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 98.7% of patients with diabetes had received influenza immunisation. The practice met all the minimum standards for QOF in asthma/COPD/palliative care/ depression amongst others.

Blood results were reviewed by a nurse practitioner, who could do this remotely and out of hours if required, for which we saw a protocol in place. Hospital discharge summaries, accident and emergency reports and other hospital letters were triaged and some filed directly by a non-clinician. Staff told us this was not overseen by the GPs. Audit of discharge correspondence had not been undertaken by a clinical member of staff to ensure that errors had not occurred. There was a risk that important information might not be reviewed and acted upon by a clinician.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had

Requires improvement

Are services effective?

(for example, treatment is effective)

been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs or prescribing nurses had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that both the nurses and GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The lead GP carried out minor surgery, including vasectomies and had attended appropriate training to do so. The practice kept a log of all minor surgery procedures, including results, complications and referrals where necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Effective staffing

Practice staffing included medical, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory (as stated by the practice) training such as basic life support, equality and diversity, moving and handling and health and safety. We noted the practice was facing challenging times to ascertain a good skill mix among the management team with the recent loss of two practice managers due to bereavement and retirement, followed by the departure of an assistant practice manager on maternity leave. This had led to return of another member of staff who had worked at the practice previously and was appointed managing officer and the need for the patient liaison director to become involved with daily practice management. This was with the full support of the lead GP who also assisted with the management processes.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

Staff had a history of appraisals that identified learning needs from which action plans were documented but these were overdue by one or two months for most staff. We were told that this was due to the recent management team shortages and recruitment challenges and this would be addressed as a matter of urgency. Our interviews with staff confirmed that the practice was proactive in providing training in addition to the mandatory elements and held regular meetings in which this was included, for example learning from individual patient scenarios.

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. Nurses we spoke with explained they peer discussed differing patient scenarios. Nurses specialised in different areas, for example safeguarding and cytology. The nursing staff we spoke with felt clinically supported by the GP but explained that having locums in the practice could propose challenges to referral or specimen processes. They previously held a regular practice nurse forum in protected time but this had not occurred for the last six months. Nurses were included within the regular practice meetings and training meetings held fortnightly in protected time. In addition the practice informed us that the practice nurses attended external practice nurse forums for support and up to date information in their roles.

Reception and administrative staff had undergone training relevant to their role. For example, records evidenced they had received training in information governance and manual handling. We saw evidence that the practice was advertising for additional staff.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, anticipatory care planning for those patients with wishes relating to hospital admission avoidance and palliative care.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice held monthly multidisciplinary team meetings, of which we saw minutes, to discuss the needs of complex patients, for example those with palliative care needs or patients recently discharged from hospital. These meetings were attended by district nurses, health visitor and palliative care nurses amongst others and decisions about care planning were documented in notes and action plans.

The practice shared their premises with community services, for example a chronic fatigue syndrome team, school nurses and Aspire (a recovery resource that supports people who misuse drugs and attended the practice weekly). Aspire informed us that they regarded the association with the practice as a very important pilot project and they explained that the doctors and other staff had been very helpful on both a personal and service level. We witnessed on the day of the inspection that a call from a patient that was under these services, that was meant for the GP, could be specifically dealt with by the service and as such ensured a more appropriate response for the patient as well a relief of the GP's workload.

The practice participated in enhanced services from the clinical commissioning group (CCG), Public Health and NHS England (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). For example, the practice had care plans for all dementia patients under the admission avoidance enhanced service.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local minor injury and illness unit, district nurses, community services, diabetic specialist nurses and the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Electronic systems were also in place for making referrals, and the practice made 85-90% of referrals last year through the Choose and Book system. (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). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. We saw evidence that all staff had received training in the safeguarding of adults as well as children. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had drawn up a consent protocol to help staff with highlighting how patients should be supported to make their own decisions and how these should be documented in the medical notes. Patients with mental health complaints and those with dementia were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing.

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. All clinical staff we spoke with 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). There was a template present on the computer system to remind staff of this when seeing an under age patient. The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. The GPs we spoke with told us they always sought written consent from patients before proceeding with treatment for minor surgery of which we saw evidence. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

Staff we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We saw that medical reviews for those patients took place at appropriately timed intervals.

2013/14 data showed that 93.8% of people with severe mental health problems registered at the practice had a comprehensive care plan documented. This was considerably above average for the CCG (76.7%) as well as nationally (86%). The practice kept a register of all patients with a learning disability. The number of patients on this register was 28 and the practice informed us they were aware of the patients' individual circumstances, including reasons why they were not able to attend the practice and the care that was in place for them. The staff explained these patients were discussed at multi-disciplinary meetings to ensure awareness of these patients.

There was a variety of information available for health promotion and prevention throughout the practice, in the waiting area and on the practice website. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home. Data showed that 1101 vaccinations were provided out of a potential 2856 patients. Others were declined or offered a recall.

The nurses we spoke with us told us there were a number of services available for patients, these included child immunisation, sexual health education, counselling, diabetes services, cervical screening, smoking cessation support and travel vaccination appointments. It was practice policy to offer a health check with a practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted a culture among the staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the patient liaison director together with the patient participation group (PPG) pro-actively offered a befriending service to patients that were lonely. The staff or PPG member would go out and visit the patients in the comfort of their own home or another suitable location upon patient request and offer this service without any clinical intervention or expectation of the patient. Staff informed us this was very successful and patients had fed back to them how much better they felt because of this. It also stimulated these patients to visit the GP if they needed to, where before they might not have been able to due to their condition.

The practice also offered NHS cardio vascular health checks to all its patients aged 40 to 75 years. The practice management informed us that a total of 211 out of 637 eligible patients, between April 2014 and April 2015, took up the offer of the health check. Staff told us how patients were followed up, initially by a nurse, if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice's performance for cervical screening in 2013/2014 was 83.5%, which was better than the average in the CCG area (81.5%) or nationally (81.9%). Patients were invited to attend via letter, with up to three reminders. A nurse would follow up patients who did not attend screening. 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 the majority of immunisations where comparative data was available was as follows:

- Flu vaccination rates for the over 65s was 74.23%. This was slightly above the national average of 73.24%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 92.5% to 98.5% and five year olds from 88.2% to 95.3%. These were slightly above CCG averages.

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 GP patient survey last updated in January 2015, which was completed by 123 respondents, and a survey undertaken by the practice's patient participation group (PPG), reflecting an unknown number of respondents. The evidence from all these sources showed patients were generally satisfied with how they were treated and whether this was with compassion, dignity and respect.

Data from the national patient survey showed the practice was rated in line with the national average of 92% for those respondents saying they had confidence and trust in the last GP they saw or spoke to. 76% described their overall experience of this surgery as good, which was lower than the national average of 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards and all were positive about the delivery of care and the involvement and attitude of staff. We received a variety of comments around the availability of appointments, with an equal balance between positive and negative. Patients stated the appointment system that the practice adopted suited them, as they could get appointments on the day if needed and speak to a doctor over the phone when convenient. Others mentioned it didn't suit them as it didn't offer continuous appointments; on the day booking did not allow enough options for forward planning. In line with this, several comments were made around the lack of continuity in seeing the same GP.

As the practice was heavily reliant on the use of locums this was a re-occurring trend in comments left on the cards as well as online (GP Patient Survey, NHS Choices). There were positive comments on the cards as well as from patients we spoke with on the day around the politeness and professionalism of staff, the cleanliness of the practice, the caring and accommodating nature of the staff and that they were listened to, despite not seeing the same GP. We spoke with thirteen patients on the day of our inspection including two representatives of the PPG. Most of them told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. There were comments around the accessibility of appointments that reflected the aforementioned views.

Approximately half the patients we spoke with did not find the appointment system in place attended to their need for future appointments. One patient commented they struggled to get an appointment on the same day.

Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. Staff respected patients and preserved their dignity and privacy.

Privacy curtains were in place in consultation rooms. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard, this was aided by the playing of the radio in the waiting area. There was a door between the waiting room and the hallway to the consultation rooms. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was not located away from the reception desk which did not assist in keeping patient information private. However, there was a sign requesting patients to wait before being called over to the reception desk. There was the option to have private conversation in person or over the phone in a separate room.

SMS text services were made available as a communication means for appointments. 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 management told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Data from the national patient survey showed the practice was rated lower at 67% than the CCG average of 83% for respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care. However, the PPG patient survey concluded that 91% of respondents responded positively when asked whether the clinician they saw asked them about their symptoms and feelings and whether the clinician listened to what they had to say.

According to the GP patient survey 84% of respondents said the last nurse they saw or spoke to was good at giving

Good

Are services caring?

them enough time and 81% said the last nurse they saw or spoke to was good at explaining tests and treatments. This was good compared to national feedback of 80% and 77% respectively.

Patients we spoke with on the day of our inspection told us that their health complaints were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt their children were dealt with in age appropriate way by the practice staff. Patient feedback on the comment cards we received was all positive around care received and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The practice also kept a register of patients that were carers, had a carer or received carer support; these patients were offered flu vaccinations and supportive information for carers was available in the waiting room.

The patient survey information we reviewed showed patients were not always positive about the emotional support provided by the practice and rated it, compared to national averages, lower for GPs but higher for nurses. For example:

73% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 82.7%.

85% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 78%.

The practice had a system for ensuring that all staff were kept up to date on the status of palliative care patients. This was to ensure appropriate care was delivered and to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient. These patients were also discussed at multi-disciplinary meetings ensuring other agencies were aware.

The GP told us they would contact suddenly bereaved families or would seek contact in end of life circumstances to provide care and support to the patients and their families. This was either followed by a patient consultation and/or by giving them advice on how to find a support service.

An information screen in the patient waiting room and patient website also told patients how to access a number of support groups and organisations, for example a Parkinson education group and Aspire, a drug dependency service.

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 patient participation group (PPG) offered a befriending service in collaboration with the practice and held monthly coffee mornings, as well as regular informative events, for example dementia talks. PPG members attend regular meetings with the practice management and GP. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG, for example the PPG claimed to continually scrutinise the appointment system to ensure call backs and consultations met the objectives and standards.

The practice told us that they engaged regularly with the NHS England Area Team and clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. The lead GP took a special interest in prescribing and the practice was signed up to a prescribing incentive plan with the CCG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times (double or triple from the standard ten minutes) were available for patients with individual needs requiring this. The majority of the practice population were English speaking patients but access to telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. Facilities were mainly on one level but in a lift was available if required, however the lead GP told us that staff would accommodate patients with mobility difficulties on the access level without making them use the lift. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not inform us of any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

For patients on an admission avoidance plan there was a named clinician. The practice had 105 of these care plans in place at the time of our visit and multi-disciplinary meetings had been held in the last year where these patients were discussed. All patients that were housebound or listed as vulnerable had a care plan in place.

The lead and salaried GPs were male but there was high use of locum GPs in the practice, this provided some flexibility for patients so they could potentially choose to see a male or female doctor. The nurses we spoke with were all female.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and it wasn't due until next year.

Access to the service

The surgery was open from 07:30 to 18:30 Monday to Friday. Appointments were available during these times depending on daily demand.

The practice made use of an automated telephone appointment booking system and had 14 incoming telephone lines. The practice felt this facilitated access for their younger patients through the use of automated technology and freed up the telephone lines for patients who may prefer to book in person on the phone or at the reception desk, 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. There were also arrangements to ensure patients received urgent medical assistance when the practice was

Good

Are services responsive to people's needs?

(for example, to feedback?)

closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients we spoke with expressed mixed opinions around the appointment system in place at the practice, where patients speak to a doctor on the phone first, upon which the doctor decides whether a face-to-face consultation is needed), with an equal balance between patients stating that this system suited them, as they could get appointments on the day if needed and speak to a doctor over the phone when convenient, and those it didn't suit as it didn't offer continuous appointments and on the day booking did not allow enough for forward planning. Patients commented that the high use of locum GPs meant the practice could not always provide a very personal service as there was a lack of continuity in seeing the same GP.

Longer appointments were available for patients who needed them and the practice offered home visits to patients requiring these. Urgent appointments were available on the day and the PPG informed us they continually scrutinised the appointment system.

The practice's extended opening hours in the mornings were particularly useful to patients with work commitments. The practice offered on site minor surgery, with the lead GP taking a special interest in vasectomies, so that patients who needed this did not need to travel elsewhere to get this done. The practice facilitated regular external services so that patients requiring these did not need to travel elsewhere. For example, a drug misuse clinic and there was a room for a school nurse.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 82% were satisfied with the practice's opening hours compared to the national average of 75.7%.
- 66% described their experience of making an appointment as good compared to the national average of 73.8%.
- 74% said they could get through easily to the surgery by phone compared to the national average of 71.8%.
- 67% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. As a result lessons learnt from individual complaints had been recognised and acted on but not always in a timely manner. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England; it was available on the intranet for all staff to access at any point. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. A leaflet was available in the practice and there was a feedback form available on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. We looked at 25 complaints received in the last 12 months and found in most cases that these were dealt with in an open and transparent manner, providing explanations, referral to the appropriate external body or apologies when required. For 11 of these complaints the practice had not responded in a timely way without informing the complainant of the delay. For two complaints we were unable to ascertain the timeframes.

The practice staff confirmed they discussed complaints in regular meetings and an analysis was done to detect themes or trends. We looked at the report for the last review and acknowledged that following a trend of complaints for a specific subject the practice had taken appropriate action.

There was a suggestion box present in the waiting room, which was monitored by the practice manager. Staff informed us this was not used by patients regularly but one patient told us that following his suggestion a clock had appeared in the waiting room.

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 staff shared the guiding principle for the practice which included providing ease of access, a responsive and flexible service, safety for patients, and a platform for a strong caring ethos to each of the population groups Staff we spoke with all knew and understood the aforementioned principles and knew what their responsibilities were in relation to these. There was a long term business plan. The lead GP told us the practice regularly engaged with the local authorities to ascertain future planning and include matters such as housing developments that could lead to increased patient list sizes. The practice had, over the previous five years, increased its list size by 33.3% and amended its practice to suit the increase, for example the recent introduction of a new appointment system.

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 20 of these policies and procedures. Staff we spoke with were able to refer back to the policies. From the 20 policies and procedures we looked at, five did not have a review date. One of these was the adult safeguarding policy. This did not state its review date but was consistent with local authority guidelines and included local authority reporting processes and contact details.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the lead GP was the lead for safeguarding. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued and knew who to go to in the practice with any concerns. There was acknowledgement from all the members of staff that the lead GP was under significant pressure with the on-going tender processes and recruitment difficulties. Comments were made by staff that indicated this was affecting the support the lead GP could provide to the staff purely from a workload point of view. Clinical staff also commented that clinical leadership was at times inconsistent due to the high use of locums and as such a constantly changing presence of GPs. Staff told us this caused issues with processes such as internal specimen handling, where the process for storage or testing was not always followed correctly by the locums. As a result this had led to samples having to be taken again, causing delays and inconvenience for the patient.

The practice used the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing above standards at 94.3% against the local average of 89.3% and a national average of 93.5%. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included chronic obstructive pulmonary disease (COPD) medicine management, diabetic medicine management and vasectomy complications. Following the COPD and diabetes audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. Evidence from other data sources, including complaints and patient comments was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice held fortnightly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance and quality had been discussed.

We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The lead GP in the practice was visible in the practice and staff told us that they were approachable and always take

Are services well-led?

Good

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

the time to listen to members of staff. However staff did mention that clinical leadership was at times inconsistent when it was reliant on locums, when the lead GP or salaried GP were not present. All staff were involved in discussions about how to run the practice within their own areas and how to develop the practice: staff told us the lead GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that regular meetings were held, including monthly practice meetings, monthly training meetings and monthly multi-disciplinary meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported.

Practice management was currently provided by the managing officer on account of the maternity leave of the substantive post holder at the time of our visit. This had forced an increase and amendment of workload on the managing officer and community liaison director. The practice had also lost two practice managers in the previous six months due to retirement and bereavement. The lead GP told us that these recent setbacks posed a considerable challenge to the day to day running of the practice. The lead GP told us that existing staff had shown dedication to ensure effective running of the practice but this was partially complicated by the inability to recruit new staff as aforementioned in this report.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG, a PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), surveys and complaints received. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

The (PPG) was proactive and claimed it had supported the practice to improve. It existed of 29 regular members and claimed to have virtual contact with 313 members. There was an even spread between male and female members and an age variation from age groups 25-34 up to patients aged 75 and over. The PPG offered a befriending service in collaboration with the practice and held monthly coffee mornings, as well as regular informative events, for example dementia talks. PPG members attend regular meetings with the practice management and GP. The PPG provided us with extensive information explaining why they felt passionate about involvement with the practice. An example would be the organisation of recent clinical talks about “dental health and treating dry mouth problems” which was attended by an excess of 40 patients from all over the county and bordering counties. The area was regarded as an excellent example of patient outreach by the British Sjögrens Syndrome Association (BSSA). This was confirmed by the BSSA.

The PPG had its own section on the practice’s website and undertook annual surveys amongst the patients. They produced reports and action plans from these surveys of which we saw evidence.

The practice was not always effective in supplying all staff with an appraisal process, we saw evidence of staff having received timely appraisals but this was not the case for all staff. We did see an action plan addressing for future development in this field. Staff explained that this had been difficult to maintain due to the recent challenges of the loss of two practice managers and the current practice manager being on maternity leave. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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. Staff told us that the practice was supportive of training and that they had monthly practice/ training meetings of which we saw evidence. The practice had completed reviews of significant events (SE) and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw minutes of training meetings which included details of actions on SE’s.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **The practice did not operate systems or processes to assess, monitor and mitigate the risks relating to the health safety and welfare of patients arising from incoming clinical documentation such as letters from hospitals. (17 (2) (b))**