Weeping Cross

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Weeping Cross on 23 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to require improvement for providing safe services. It was good for providing an effective, caring, responsive service and well led. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks and chaperoning.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Most 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.
- Some patients had waited up to two weeks for an appointment with a doctor of their choice but appreciated that they could use the sit and wait clinic if they needed to be seen on the day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Appropriate arrangements were not in place for the recording, handling and dispensing of controlled drugs within the practice's dispensary. Following our inspection we received written confirmation that they had stopped dispensing controlled drugs.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients which it acted on.

We saw one area of outstanding practice:

- The practice had a large number of university students registered at one of their branch practices. They held a Fresher's weekend once a year to support new students to register with them. Health checks were also offered to these students.

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

Importantly the provider must:

- Ensure that receptionists who chaperone have been risk assessed to determine if a Disclosure and Barring Service (DBS) check is required. DBS checks are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Importantly the provider should:

- Ensure that all staff who chaperone receive the appropriate support to help them in this role.
- Introduce cleaning records to monitor that cleaning is carried out daily in line with the cleaning schedule.
- Ensure that there is a system in place to identify vulnerable adults, children or people experiencing poor mental health with a high number of accident and emergency attendances.
- Ensure that GP prescription pads are handled, stored and tracked in accordance with national guidance.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, receptionists who chaperoned had not been risk assessed to determine if a Disclosure and Barring Service (DBS) check was required. DBS checks are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Systems were not in place to ensure that appropriate arrangements were in place for the recording, handling and dispensing of controlled drugs within the practice's dispensary. Following our inspection we received written confirmation that the practice had stopped dispensing and storing controlled drugs.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed most 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. Most 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.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Some patients told us they had waited up to two weeks for an appointment with a doctor of their choice but appreciated that they could use the sit and wait clinic if they needed to be seen on the 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. We saw that learning from complaints was shared with staff.

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 and held regular governance meetings. There were systems in place to monitor and improve quality. Whilst the practice was able to describe how they managed risks in the practice, formal risk assessments had not always been completed or monitored on the risk log. Following the inspection, the practice manager forwarded a risk assessment and an updated risk log that demonstrated a risk we had identified was being appropriately managed. The practice proactively sought feedback from staff and patients, which it acted on. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered 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.

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. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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. However, a system was not in place to identify children and young people who had a high number of accident and emergency attendances. Childhood immunisation rates were in line with regional immunisations rates. 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 midwives and health visitors.

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. The practice offered a full range of health promotion and screening that reflects the needs for this age group. The practice had

Summary of findings

a large number of university students registered at one of their branch practices. They held a 'Fresher's' weekend once a year to support new students to register with them. Health checks for students were also offered to these students.

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 travellers and those with a learning disability. The practice told us that there were 22 patients with a learning disability registered with the practice but none of these patients had an agreed care plan in place.

The practice regularly 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. 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 in normal working hours and out of hours.

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). Seventy-five per cent of people with a diagnosis of dementia had received an annual physical health review. Seventy-nine per cent of people experiencing poor mental health had an agreed care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told people experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE.

Summary of findings

What people who use the service say

All of the eight patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 20 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were positive. Patients told us the staff were caring, kind, friendly and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients told us they had waited up to two weeks for an appointment with a doctor of their choice but appreciated that they could use the sit and wait clinic if they needed to be seen on the day.

The results from the National Patient Survey showed that 85% of respondents said that their overall experience of the practice was good or very good. This was slightly below the Clinical Commissioning Group (CCG) regional average of 88%. However, 84% of respondents said they would recommend the practice to someone new to the area which was above the regional CCG average of 83%.

Areas for improvement

Action the service MUST take to improve

Ensure that receptionists who chaperone are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required. DBS checks are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Action the service SHOULD take to improve

Ensure that all staff who chaperone receive the appropriate support to help them in this role.

Introduce cleaning records to monitor that cleaning is carried out daily in line with the cleaning schedule.

Ensure that there is a system in place to identify vulnerable adults, children or people experiencing poor mental health with a high number of accident and emergency attendances.

Ensure that GP prescription pads are handled, stored and tracked in accordance with national guidance.

Outstanding practice

The practice had a large number of university students registered at one of their branch practices. They held a 'Fresher's' weekend once a year to support new students to register with them. Health checks were also offered to these students.

Weeping Cross

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor, a second CQC inspector and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Weeping Cross

A team of six GP partners, four salaried GPs, a GP registrar (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine), four nurses and a health care assistant provide care and treatment for approximately 18,400 patients. Weeping Cross works from three separate sites and patients can attend any of these practices:

Weeping Cross Health Centre is the main practice and moved to this location in 1990. The practice provides primary medical services to patients living in Stafford, Staffordshire. It has a dispensary facility for patients who live more than one mile from their nearest pharmacy.

Beaconside Health Centre is a branch practice with a catchment area that includes Staffordshire University and Stafford Ministry of Defence barracks. We did not inspect this practice during our inspection on 23 March 2015.

John Amery Drive is a branch practice located in Stafford. It provides primary medical services to patients living in Stafford. We did not inspect this practice during our inspection on 23 March 2015.

The practice is a training practice for GP registrars and medical students to gain experience and higher qualifications in General Practice and family medicine. The practice does not routinely provide an out-of-hours service to their own patients but patients were directed to Badger out-of-hours services when the practice was closed.

Why we carried out this inspection

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

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?

Detailed findings

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 carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with the chairperson of 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. The practice provided care within seven care homes for older people. We spoke with representatives from two of these care homes. We also spoke with a health visitor and a district nurse who worked with the practice. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 23 March 2015 at the practice. During our inspection we spoke with four GP partners; a salaried GP; a GP registrar; two nurses and a health care support worker; a dispenser; two receptionists; three administrative staff; the practice manager and eight patients. We observed how patients were cared for. We reviewed 20 comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts 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 report incidents and near misses. For example, we saw that an incident had occurred whereby the temperature of one of the vaccine fridges had significantly exceeded the temperature range advised by the vaccine manufacturers. We saw that appropriate action had been taken and the issue raised as a significant event. Following analysis of the significant event we saw that procedures for monitoring the fridge temperature range had been amended, policies updated and the fridge replaced.

We reviewed safety records, incident reports and minutes of monthly significant event meetings where these were discussed. We saw that 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, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held each month to review actions from past significant events. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked five significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of learning following significant events. 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 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 monthly staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw that following an alert regarding the use of a medicine used to lower blood cholesterol and a medicine to reduce high blood pressure that a medication audit had been carried out. We saw that where needed, patients were called in for a review of their medication to ensure they received the correct dosage of these medicines.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. 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 hours. Contact details were easily accessible and displayed throughout the practice.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. Prior to our inspection, we spoke with a health visitor who worked with the practice. They told us that the GPs worked closely with the health visiting service to support children and their families. The health visitor told us that there was also a system in place that ensured that the health visiting service was made aware of new children who registered with the practice.

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.

Requires improvement

Are services safe?

There was a chaperone policy, which staff could access through their practice intranet. 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. Signs informing patients of their right to have a chaperone present during an intimate examination were displayed throughout the practice. Nursing staff we spoke with told us they had received chaperone training during their nurse training. They clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse. Two reception staff told us they had acted as a chaperone if nursing staff were not available. They told us they had not received formal chaperone training to help them to understand their responsibilities when acting as chaperones. However, the receptionists we spoke with did recognise the need to be able to clearly observe the examination and were aware of what action to take if they had any concerns.

The safeguarding lead told us that when they received accident and emergency (A&E) discharge letters that they were reviewed by a GP. However, there was no system in place that identified vulnerable adults, children or people experiencing poor mental health with a high number of A&E attendances. There was no system in place to identify if there was a pattern to these admissions.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. A log of the fridges' temperature ranges had been recorded twice daily which demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff that we spoke with understood why and how to follow the procedures identified in the policy.

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 nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. We saw that prescription pads were stored in locked cupboards. However, blank prescription forms were not always handled in accordance with national guidance. There was no system in place to check that GP prescription pads used for home visits were tracked through the practice.

The practice offered a dispensary service for patients who lived more than one mile to their nearest pharmacy. We saw records that showed staff involved in the dispensing process had received appropriate training. Dispensing staff at the practice told us that all prescriptions were signed by a GP before being dispensed. The dispensary held stocks of controlled drugs (CDs) and had in place standard operating procedures that set out how they were managed. CDs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

We looked at the CD log book to check that appropriate arrangements were in place for the recording, handling and dispensing of controlled drugs within the practice's dispensary. The practice's dispenser told us either they or one of the GPs dispensed the CDs to patients. We saw that there was no audit trail of who had accepted CDs into the practice or who had dispensed the CDs to patients. We looked at the CD log book to check that the practice kept a record of the number and types of CDs they held in their secure CD cupboard. We saw that the number of CDs were not clearly identifiable. We tracked three CDs recorded in the CD log book. We saw that the number of tablets for each type of CD received into the practice did not tally with the number of tablets dispensed or held by the practice. The practice could not explain where the missing tablets were. We also found CDs stored in the CD cupboard that

were not recorded or accounted for in the CD log book. We have shared our findings with the CD accountable officer for NHS England. Following our inspection we received written confirmation that the practice had stopped dispensing and storing controlled drugs.

We asked one of the GP partners what systems they had in place to monitor the quality of the dispensing process. They told us that there were no systems in place.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there was a cleaning plan in place but there were no cleaning records to monitor that cleaning had been carried out daily in line with the cleaning schedule. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had two leads for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role. We saw evidence that the leads had carried out regular infection control audits and that any improvements identified for action were completed on time. For example, hand washing gel had been made more readily available throughout the practice.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had started to introduce steps to protect staff and patients from the risks of health care associated infections. We saw records that demonstrated that three clinical staff had received the relevant immunisations and support to manage the risks of health care associated infections. The practice nurse told us they were in the process of monitoring that other clinical staff had received the same protection. We saw that a legionella risk assessment had been completed in October 2013 to protect patients and staff from harm. We saw that appropriate action had been taken to address any risks identified. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms

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 and we saw equipment maintenance logs and other records that confirmed this. We saw records that demonstrated all portable electrical equipment had been tested in May 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in March 2015 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included proof of identification, references, qualifications and registration with the appropriate professional body.

We saw that Disclosure and Barring Service checks (DBS) had been carried out for all clinical staff working at the practice. DBS checks are carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. DBS checks had not been carried out for non-clinical staff. There were no risk assessments to demonstrate how the practice had come to the decision that staff did not require a DBS check. In addition, two receptionists told us that they had chaperoned for GPs but no risk assessment or DBS check had been completed to demonstrate they were suitable to carry out this role

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. The practice manager showed us records to demonstrate that actual

staffing levels and skill mix were in line with planned staffing requirements. We saw that staffing rotas were planned in advance to ensure adequate staffing levels were maintained.

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. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. This included a fire risk assessment and fire drills for staff; gas safety checks; emergency lighting tests and fire alarm testing. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

We saw that where risks were identified that action plans had been put in place to address these issues. The practice manager showed us the practice's risk management report and an agenda for an action log meeting to discuss the risks identified in the report. However, we identified a risk that had not been formally risk assessed or monitored on the risk log. The provider was able to describe to us the systems they had in place to monitor this risk but had not formally recorded this. Following our inspection, the practice manager forwarded to us a copy of a risk assessment and an updated risk log which demonstrated how this risk was being managed.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required although this may be through the sit and wait clinic held at the practice. The health visitor we spoke with also confirmed this. The lead GP told us that the local Clinical Commissioning Group (CCG) informed them of their most vulnerable patients so they could provide additional support if needed. We spoke with a district nurse who told us that they had a positive working relationship with the practice. They attended monthly multidisciplinary meetings at the practice to discuss the care and support for vulnerable patients and those requiring palliative care.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly to ensure it was fit for purpose.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. 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 rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and the loss of domestic services.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that a practice fire drill had been carried out last year. We saw that there was a yellow triangle warning sign on the door of the room where the oxygen was stored to alert the fire service of the presence of oxygen if a fire were to occur at the practice.

Good

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). For example, one of the GP partners described how they had used the NICE guidelines for the management of high blood pressure in patients. We saw that the GPs and nurses used clinical templates in the management of patients care and treatment. This assisted them to assess the needs of patients with long term conditions, older patients and patients experiencing poor mental health. 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. Patients with learning difficulties however did not routinely receive an annual review unless they had a long term condition or required a medication review.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. We saw training certificates which demonstrated that practice nurses had received the additional training they required for the review of patients with long term conditions such as coronary heart disease and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

All the GPs we spoke with used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks.

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 patients' age, gender 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 information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last 18 months. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of patients on a medicine used in the treatment of diabetes had been carried out. Research showed there is an association between vitamin B12 deficiency and the long term use of this medicine. The aim of the audit was to identify patients on this medicine with low vitamin B12 levels and to provide treatment where required. After two cycles of this audit the practice were able to demonstrate that the number of patients with diabetes who had been tested had risen from 9% to 66%. Other examples included an audit of the unintentional prolonged treatment with a medicine used to prevent blood from clotting and the rate of inadequate smear samples.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). 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. For example, QOF data demonstrated that the practice was above the national average for the prescribing of certain types of antibiotics. We saw that an audit of antibiotic prescribing rates had been carried out which resulted in a review of the practice's

Good

Are services effective?

(for example, treatment is effective)

antibiotic prescribing guidelines. The practice were able to demonstrate that following this review there had been a significant and sustained reduction in the number of antibiotics prescribed by the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 94% of patients with chronic obstructive pulmonary disease (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema) and 76% of patients with asthma had received an annual review. These results were above the national target. The practice was less proactive in implementing care plans for patients experiencing poor mental health. Only 80% of these patients had an agreed care plan in place compared with the national target of 90%. The practice told us that there were 22 patients with a learning disability registered with the practice but none of these patients had an agreed care plan in place.

There was a protocol for repeat prescribing which was in line with national guidance. We saw that 87% of patients on regular medication had received an annual medication review. In line with this, staff regularly checked that patients who received repeat prescriptions had 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.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of five patients and alerts within the clinical computer system making clinical staff aware of their additional needs.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data highlighted areas where the practice was performing well and areas they needed to improve. For example, it demonstrated that the practice was performing well in the number of elective patient hospital admissions but the prevalence of patients with a diagnosis of dementia was low.

Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that clinical staff were up to date with attending mandatory courses such as basic life support. However, not all non-clinical staff had completed basic life support training.

We noted a good skill mix among the GPs. One GP had a diploma in sexual and reproductive healthcare, three GPs had diplomas in children's health and one GP had a diploma in obstetrics and gynaecology. All the GPs we spoke with 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. As the practice was a training practice, GP registrars who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of childhood immunisations and cervical screening. Those with extended roles such as in coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of 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

Good

Are services effective?

(for example, treatment is effective)

both electronically and by post. The practice had a policy 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. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record.

We spoke with a health visitor and district nurse prior to our inspection who confirmed the practice worked effectively them and were proactive in sharing information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence that the practice had used significant events to learn and improve information sharing between the practice and other providers.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. 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. We saw there was a MCA 2005 policy in place to support staff in making decisions when capacity was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us that 75% of these care plans had been reviewed in the last year. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. 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).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, there was a formal consent form for patients to sign which demonstrated they were aware of the relevant risks, benefits and complications of the procedure. Consent forms were scanned into patients' notes. We saw an anonymised record where this had been completed.

Health promotion and prevention

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the regional Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations

There were systems in place to support the early identification of cancers. The practice carried out cervical screening for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical smear uptake was 82% which was above the national target of 80%. The practice was also proactive in screening for cancers such as bowel and breast cancer. They provided a confidential chlamydia screening service for young people and saw this had been accessed by 195 patients. The practice nurses held smoking cessation clinics. Practice data showed that smoking cessation advice had been offered to 2447 patients over the last year and that 18% of these patients had stopped smoking following this support. Practice nurses described to us how they sign posted patients to weight loss clinics and completed exercise referrals for patients who needed to manage their weight.

Good

Are services effective?

(for example, treatment is effective)

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 kept a register of 22 patients with a learning disability. Annual health reviews were not routinely carried out for these patients but the practice told us that they working with the CCG learning disability nurse to support these patients. The practice held well women clinics. One of the nurses at the practice also carried out pelvic floor assessments for stress incontinence.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The Quality Outcome Framework (QOF) data showed that the practice was below national standards in providing flu immunisations for the target groups of patients. We saw that the practice had put an action plan in place to address this issue.

The practice had approximately 2000 university students registered at one of their branch practices. The university was proactive in registering students with a disability and students from other countries. The practice held a Fresher's weekend once a year to support new students to register with them. They also provided health checks for students that registered with the practice. This was particularly helpful for foreign students and students with disabilities to support them to access health promotion services.

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 112 replies to the national patient survey carried out during January-March 2014 and July-September 2014. The evidence showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the results from the national patient survey showed that 85% of respondents said that their overall experience of the practice was good or very good and 84% of respondents said they would recommend the practice to someone new to the area. These results were generally in line with the CCG regional average. The practice was slightly below the CCG regional average for its satisfaction scores on consultations with GPs. For example, 86% of respondents said the GP was good at listening to them and 83% said the GP gave them enough time. The CCG regional average was 87% and 89% respectively. However, the practice was above the CCG regional average for its satisfaction scores on consultations with nurses. For example, 94% of respondents said the nurse was good at listening to them and 100% of respondents said the nurse gave them enough time. The CCG regional average was 83% and 85% respectively.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 20 completed cards and all were positive about the service experienced. Patients said the staff were caring, kind, friendly and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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 position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff that we spoke with were aware of the difficulties but had systems in place to maintain patient's confidentiality. These included taking patients to private rooms to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the surgery for investigation results.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. 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 they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the national patient survey showed 73% of practice respondents said the GP involved them in care decisions and 80% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG regional average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We spoke with a district nurse who worked with the practice to provide care and support to vulnerable, older patients. They told us that the practice was proactive in

identifying and communicating concerns about older patients registered with the practice. They told us that they worked with the practice to involve these patients in decisions about their care. Structured multi-disciplinary meetings were held at the practice on a four weekly basis to discuss the care of these patients. We saw minutes from meetings that confirmed this.

We spoke with representatives from two care homes for older people. They told us that all the patients living there who were registered with Weeping Cross had a named GP and received regular medication reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNACPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and important others. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern and with a score of 97% for the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The lead GP told us that if families had suffered a bereavement, their usual GP contacted them. If necessary, they also signposted them for bereavement support and counselling provided by the local hospice.

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 patients' 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. For example, the practice had approximately 2000 university students registered at one of their branch practices. The university was proactive in registering students with a disability and students from other countries. The practice held a Fresher's weekend once a year to support new students to register with them. They also provided health checks for students that registered with the practice. This was particularly helpful for foreign students and students with disabilities to support them to access healthcare services. There was also a military base close to the practice. Many of the military personnel and their families had registered with one of the branch practices. We saw that there was a psychologist attached to this practice who provided support for military personnel when they experienced poor mental health following deployment to other countries.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from 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. We spoke with a person from the PPG who told us that following their patient survey in 2014 of 425 patients, that concerns had been raised regarding the time patients had to wait to be seen at the sit and wait clinic. This was a particular problem for the working aged population as they took time off from work. After consultation with the practice, it was agreed that if a patient's condition was not urgent and there was a prolonged waiting time at the sit and wait clinic that they could request a telephone consultation with a GP after the morning sit and wait clinic had closed.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor of the building. Although at times the waiting area was very busy, it was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included two disabled parking spaces; step free access to the electronic front door of the practice; disabled toilets and a hearing loop for patients with a hearing impairment.

For patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

The practice provided care and support to several house bound elderly patients and 70 patients living in local care homes. Patients over 75 years of age had a named GP to ensure continuity of care. We spoke with representatives from two of the care homes who told us that the practice always responded quickly to a request for a patient to be seen at the home.

The practice provided care and treatment for a small travelling community. They told us that travelling families were supported to register as temporary residents with the practice. The practice held a register of 22 patients with a learning disability registered with the practice but none of these patients had an agreed care plan in place to support their needs.

Access to the service

The practice offered a variety of ways in which patients could access appointments. A sit and wait clinic was provided at the main practice each midweek morning from 8am till 10am. Pre-bookable appointments were available at all three practices and on the day urgent appointments were also available. If there was a long wait for the sit and wait appointments, patients could request a GP telephone consultation after the clinic had finished. The practice's extended opening hours were particularly useful to

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients with work commitments and school age children. Extended hours appointments were available four days a week. Home visits were available on request for patients who were housebound, terminally ill or too ill to attend the practice. When the practice was closed, patients were directed to Badger out of hours service for care and treatment. We saw from the PPG action plan that the practice were working with the PPG to explore the use of alternative methods of consultation through the use of video telecommunications software.

Comprehensive information was available to patients about appointments on the practice's website. This included how to arrange urgent appointments and home visits and how to cancel appointments through the website.

We looked at the national patient survey results published in January 2015 and saw that 72% of respondents described their overall experience of making an appointment as good or very good compared with the regional CCG average of 77%. Patients we spoke with were generally satisfied with the appointments system. Some patients commented that it could take several weeks to get a pre-bookable appointment with their GP of choice. Many patients commented favourably about the sit and wait clinic stating it meant they were seen on the day they were ill.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that there was information on the practice website and a poster in the waiting room informing patients how to complain.

We looked at eight complaints received in the last 12 months and found they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw practice meeting minutes that demonstrated complaints were a regular agenda item and learning from them was shared with staff. This supported staff to learn and contribute to any improvement action that might have been required.

The practice reviewed complaints to detect themes or trends. We looked at their annual complaints review report for the previous 12 months. We saw that lessons learned from individual complaints had been acted on.

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 standards of care and provide excellent services for patients, staff and the wider healthcare community'. We found details of the vision and practice values were part of the practice's three year business plan. The practice values included to provide increased support for patients with long term conditions; to remain flexible to change as services expand, modernise and improve; to respond and adapt to local health care issues on an ongoing basis; to provide an educational and learning environment for all staff and to develop as a centre of excellence for medical training for GPs and nurses.

We spoke with 16 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Prior to our inspection we spoke with representatives from two care homes where the practice provided care and support to patients and they confirmed that the practice worked in line with these values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet. We looked at 14 of these policies and procedures. We saw that eight of these policies were not dated to reflect the date they were reviewed. The practice manager had only been in post six months and told us that they were in the process of updating all the policies. They also told us they were working with an external human resources company to update their employment and health and safety policies. We saw that this risk had been included in the practice's risk management log and that it was a standing agenda item on the fortnightly partners' meetings. There was a clear action plan in place outlining how this risk was being managed and the date of review.

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 a GP lead for safeguarding. We spoke with 16 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. 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 QOF data for this practice showed it was performing in line with national standards with a practice value of 94.1% compared with a national value of 94.2%. We saw that QOF data was regularly discussed at monthly governance meetings. We saw that actions had been taken to maintain or improve patient outcomes. These included a review of the guidelines for prescribing certain antibiotics and an action plan to increase the number of patients provided with the flu vaccination.

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 patients on a medicine used in the treatment of diabetes had been carried out. Research showed there is an association between vitamin B12 deficiency and the long term use of this medicine. The aim of the audit was to identify patients on this medicine with low vitamin B12 levels and to provide treatment where required. After two cycles of this audit the practice were able to demonstrate that the number of patients with diabetes who had been tested had risen from 9% to 66%.

The practice had arrangements for identifying, recording and managing risks. The practice manager had developed a risk log which identified the level of impact each risk posed to the practice, a risk lead, a plan of action and a review date. We saw that this was integrated into the practice's three year business plan. The risk log identified nine risks to the practice, for example the availability of space to store records and the need for policies to be reviewed in a timely manner. However, it did not include the potential risk of receptionists who chaperoned who did not have a Disclosure and Barring Service check in place. DBS checks are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We identified another risk that had not been formally risk assessed or monitored on the risk log. The provider was able to describe to us the systems they had in place to monitor this risk but had not formally recorded this. The provider was able to describe to us the systems they had in place to monitor this risk but

Are services well-led?

Good

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

had not formally recorded this. Following our inspection, the practice manager forwarded to us a copy of a risk assessment and an updated risk log which demonstrated how this risk was being managed.

Governance arrangements for the management of controlled drugs (CDs) in the practice's dispensary were not in place. CDs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We asked one of the GP partners what quality monitoring they had in place for the recording, handling and dispensing of controlled drugs within their dispensary service. They confirmed that there was no quality monitoring system in place. We found that the number of CDs held at the practice were not in line with what was recorded in the CD log book. We have shared our findings with the CD accountable officer for NHS England. Following our inspection we received written confirmation that the practice had stopped dispensing and storing controlled drugs.

Leadership, openness and transparency

Practice meetings were held monthly and staff received monthly one to one supervision. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the practice intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and disciplinary procedures which were in place to support staff. We were shown the electronic staff handbook that was available to all staff which included sections on equality, whistleblowing and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the patient participation group (PPG) patient survey for 2013 – 2014 and saw that 70% of patients were satisfied with the appointment system. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. However, in the written comments patients made about how the practice could improve, a common theme of long waiting times at the sit and wait clinic was identified. As a result of this, a system had been introduced that enabled patients to request a telephone consultation with a GP after the clinic had finished if the clinic was very busy and their condition was not urgent.

The practice had an active PPG and consisted of 23 members. The PPG included male and female members with an age range of 44 years and above. The PPG met quarterly with staff members and GP partners from the practice. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff 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. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had monthly protected learning time.

The practice was a training practice for medical students and GP registrars to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with one GP registrar on the day of our inspection. They told us they were well supported by the practice and described how they had been supported in their learning.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this.

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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers We found that the registered person had not protected people against the risk of receiving unsafe care and treatment because information specified in Schedule 3 was not available for some staff. Disclosure and Barring Service checks and risk assessments had not been carried out for non-clinical staff who chaperoned. This was in breach of regulation 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.