

80 Tettenhall Road Surgery

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 80 Tettenhall Road Surgery on 18 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to require improvement for providing safe services. We found the practice to be good for providing effective, caring, responsive and well-led services. It was found to be 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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. 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.
- Most patients said they found it easy to make an appointment. Urgent appointments were available within 48 hours. On the day appointments were available for children and vulnerable adults.

Summary of findings

- 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:

- There was a system in place to ensure that vulnerable adults received appropriate care and treatment. The practice maintained a list of 11 vulnerable adults and reception staff actively recorded when they were seen. Reception staff telephoned these patients each month if they had not visited the practice, to enquire about their health and wellbeing. Where appropriate, appointments were made for these patients to be seen by the GP.

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

Importantly the provider must:

- Ensure that appropriate staff have been subject to, or been risk assessed for the need to have a Disclosure and Barring Service check carried out. They should also put in place a system to monitor that the practice nurse's professional registration is in date to ensure they are fit to carry out their role.

In addition the provider should:

- Put measures in place, such as installing a switchless socket or clearly labelling the vaccine fridge plug with a cautionary notice, to prevent the accidental interruption of the electricity supply to the vaccine fridge.
- Ensure fire drills are carried out regularly to ensure that staff are aware of how to safely evacuate patients in the event of a fire. An oxygen warning sign should be fitted to the door of the room where the oxygen cylinder is stored to alert the fire service to its presence in the event of a fire.
- Ensure there is a system in place to review and update policies and procedures in a timely manner.
- Ensure that risk assessments are completed and an action plan put in place to manage all identified risks.
- Ensure that the facilities in place to support patients with mobility disabilities are fit for purpose and meet their needs.

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?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

However, risk assessments and action plans were not always put in place to manage all identified risks. For example, the risk of using an answer machine to record repeat prescription requests. The practice had not carried out Disclosure and Barring Service (DBS) checks for reception staff who chaperoned and the practice nurse to ensure they were suitable to work with children and vulnerable adults. 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.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. 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.

Good



Are services caring?

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.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Good



Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a GP or nurse. Urgent appointments were available the same day for children and vulnerable adults and within 48 hours for other patients. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Complaints were responded to in a timely manner however learning from complaints was not always shared with staff.

There were some arrangements in place to support patients with mobility disabilities however they were not always fit for purpose.

Are services well-led?

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. Many of the policies had not been reviewed on a regular basis. The practice manager had identified this need within in their appraisal and an action plan had been put in place to address this issue. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Staff had received inductions, regular performance reviews and attended staff meetings.

Good



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

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 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.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and most patients had an 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.

Good



Families, children and young people

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, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively 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.

Good



Working age people (including those recently retired and students)

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 promoted continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice maintained a list of 11 vulnerable adults and reception staff actively recorded when they were seen. Reception staff telephoned these patients each month if they had not visited the practice, to enquire about their health and wellbeing. Where appropriate, appointments were made for these patients to be seen by the GP. It had carried out annual health checks for people with a learning disability and six out of 13 of these patients had received a follow-up. The practice offered longer appointments for people with a learning disability.

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. However, not all staff had received training in safeguarding vulnerable adults. 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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Eighty-five per cent of people with a diagnosis of dementia had a 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 provided a shared care service for patients with substance misuse problems. Shared care is a partnership between the GP and a worker from a substance misuse agency. The GP provided a substitute prescription for the patient and the worker provided support for the patients' social and emotional needs.

Good



Summary of findings

What people who use the service say

All of the nine patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 45 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 most comments were positive. Patients told us the staff were helpful, professional, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice always appeared clean and tidy. Some patients told us they experienced problems getting through to the practice on the telephone to make an appointment. Most patients however told us the appointment system was easy to use and met their needs.

The results from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 96% of patients said that their overall experience of the practice was good or very good and that 88% of patients would recommend the practice to someone new to the area. This was significantly above the Clinical Commissioning Group (CCG) regional average of 84% and 72% respectively. Data from the Family and Friends test carried out between October 2014 – April 2015 supported these findings. Sixty-seven out of 68 patients stated that they were likely or very likely to recommend the practice to their friends and family.

Areas for improvement

Action the service **MUST** take to improve

Ensure that appropriate staff have been subject to, or been risk assessed for the need to have a Disclosure and Barring Service check carried out. They should also put in place a system to check that the practice nurse's professional registration is in date to ensure they are fit to carry out their role.

Action the service **SHOULD** take to improve

The provider should put measures in place, such as installing a switchless socket or clearly labelling the vaccine fridge plug with a cautionary notice, to prevent the accidental interruption of the electricity supply to the vaccine fridge.

The provider should ensure fire drills are regularly carried out so that staff are aware of how to safely evacuate

patients in the event of a fire. An oxygen warning sign should be fitted to the door of the room where the oxygen cylinder is stored to alert the fire service to its presence in the event of a fire.

The provider should ensure there is a system in place to review and update policies and procedures in a timely manner.

The provider should ensure that risk assessments are completed and an action plan put in place to manage all identified risks.

The provider should ensure that the facilities in place to support patients with mobility disabilities are fit for purpose and meet their needs.

Outstanding practice

There was a system in place to ensure that vulnerable adults received appropriate care and treatment. The practice maintained a list of 11 vulnerable adults and reception staff actively recorded when they were seen.

Reception staff telephoned these patients each month if they had not visited the practice, to enquire about their health and wellbeing. Where appropriate, appointments were made for these patients to be seen by the GP.

80 Tettenhall Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor 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 80 Tettenhall Road Surgery

The 80 Tettenhall Road Surgery provides primary medical services for patients living within their practice boundary in Wolverhampton and the surrounding areas. The practice has a contract to provide General Medical Services for patients. This is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice provides a number of specialist clinics and services. For example long term condition management including asthma, diabetes and high blood pressure. It also offers a phlebotomy service (the taking of blood from a vein for investigations) and childhood and travel vaccinations.

A team of two GPs; a GP registrar (GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine); a practice nurse; a health care assistant; a practice manager and six administrative staff provide care and treatment for approximately 3400 patients. There is one female and one male GP.

The practice has been a training practice for GP registrars to gain experience and higher qualifications in general practice and family medicine since 2009.

The practice is open between 8.30am and 6.30pm Monday to Wednesday. It is open between 8.30am and 1pm on Thursdays and 8.30am and 6pm on Fridays.

GP appointments are available between 8.30am to 11.20am each morning. However, on Thursday mornings GP appointments are available until 12pm and appointments start from 8am on Friday mornings. GP appointments are also available between 3pm and 5pm Monday to Friday with the exception of Thursday afternoons when it is closed. Extended hours surgeries are offered on Monday evenings between 6.30pm to 7.30pm. The practice does not routinely provide an out-of-hours service to its own patients but they have alternative arrangements for patients to be seen by Prime Care out of hours service when the practice is 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 (Regulated Activities) Regulations 2014 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 (Regulated Activities) Regulations 2014, 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.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

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

Before 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 managers of two care homes where the practice provided care and treatment to several patients who lived there. We also 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. 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 18 May 2015 at the practice. During our inspection we spoke with the two GP partners; a GP registrar; a nurse and a health care assistant; three receptionists; an administrator; the practice manager and nine patients. We observed how patients were cared for. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the service.

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, one member of staff described to us the changes made to the collection of prescriptions by local pharmacies following an incident when a prescription went missing.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last seven years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last seven years and we were able to review these. Significant events were a standing item on the practice meeting agenda and dedicated meetings had been held 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, felt encouraged to report significant events.

Staff used significant event forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor significant events. We tracked three significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of these 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 to the practice staff and pharmacy advisor. When alerts regarding medicines had been received, we saw that the pharmacy advisor had carried out audits of patients receiving these medicines. We saw that action had been taken to amend

patients' medicines if it was appropriate to do so. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, the withdrawal of a medicine used in the treatment of diabetes. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 in safeguarding children. However, only two members of staff had received training in safeguarding vulnerable adults. The practice manager told us they had been trying to arrange training for staff and we saw evidence of this. 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.

The practice had appointed a dedicated GP as a 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 the clinical staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. Non-clinical staff told us they would inform the practice manager. We saw that there was a system in place to identify and follow up children who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

There was a system in place to ensure that vulnerable adults received appropriate care and treatment. The practice maintained a list of 11 vulnerable adults and reception staff actively recorded when they were seen. Reception staff telephoned these patients each month if they had not visited the practice, to enquire about their health and wellbeing. Where appropriate, appointments were made for these patients to be seen by the GP. There was a system to highlight vulnerable patients on the

Are services safe?

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.

Signs informing patients of their right to have a chaperone present during an intimate examination were clearly displayed on the doors of consultation and treatment rooms and in the reception area. 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. Nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination and the actions to take if they had any concerns.

We reviewed three staff files and saw that the practice nurse and the receptionists who chaperoned had not had a Disclosure and Barring Service (DBS) check carried out by the practice to ensure they were a suitable person to carry out this role. No risk assessments had been completed to demonstrate how this decision had been made or what the practice would do to ensure patients were protected from the risk of abuse. 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.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. However, measures had not been put in place, such as installing a switchless socket or clearly labelling the vaccine fridge plug with a cautionary notice, to prevent the accidental interruption of the electricity supply to the vaccine fridge.

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 Clinical Commissioning Group (CCG) benchmarking data that demonstrated the practice was below the regional average for its antibacterial prescribing. This showed that the practice recognised the importance of appropriately prescribing antibiotics. Audits had also been carried out by the practice's pharmacy advisor to monitor some medicines used for patients with long term conditions. Where changes to medications were identified, we saw that the GPs made the appropriate changes to the patient's medication.

The practice nurse 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 nurse had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Reception staff we spoke with understood their roles and responsibilities in providing repeat prescriptions. There was a medicine management policy available for staff to refer to for help and support. However, clinical and non-clinical responsibilities were not always clearly defined. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Patients requested repeat prescriptions face to face, on line or over the telephone. There was an answer machine available for patients to leave requests for repeat prescriptions.

Cleanliness and infection control

We saw there were cleaning schedules in place and daily cleaning records were kept. Patients we spoke with told us they always found the practice to be visibly clean and had no concerns about cleanliness or infection control. However, we observed some areas of the practice were in need of improvement. For example, the light pull cords in the patients' toilets were dirty and there was an old soap bar in the staff toilets for staff to wash their hands with.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff

Are services safe?

received training about infection control specific to their role. We saw evidence that the lead had carried out monthly hand washing audits and three monthly practice audits. Any improvements that had been identified for action were completed on time.

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. For example, personal protective equipment including disposable gloves, aprons and body fluid spillage kits were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. 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 taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that appropriate staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that a legionella risk assessment had been completed in May 2013 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. 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 July 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in July 2014 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 policy for the recruitment of new staff but it did not reflect legal recruitment requirements. For example, it did not identify the need to obtain proof of

identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the DBS. The practice manager told us they would update the policy to reflect these requirements. Within two working days we received evidence that the policy had been updated and met legal requirements.

We looked at three staff files and saw that some of the legal recruitment requirements had been carried out. For example, references for staff. However, DBS checks had not been carried out by the practice for the practice nurse or receptionists who chaperoned. In addition, there was no system in place for ensuring that the practice nurse's professional registration was in date to ensure they were fit to carry out their role.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Reception staff were trained in all areas of reception work to ensure that when one member of staff was off, another member of the team could cover their responsibilities.

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 their business continuity plan which outlined the action they would take in the event of staff shortages.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The general maintenance of the building was carried out by the landlord. We saw records that demonstrated checks of the building had been carried out. These included a fire risk assessment; gas safety checks and a legionella risk assessment. The practice had completed general risk assessments. For example, the risk of slips and trips, waste disposal and manual handling. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

We saw that the practice had a robust shared care substance misuse policy and system in place for the prescribing of medicines for patients with substance misuse problems. This demonstrated that the practice

Are services safe?

recognised the risks of harm resulting from substance misuse and substitute prescribing. Shared care is a partnership between the GP and a worker from a substance misuse agency. The GP provided a substitute prescription for the patient and the worker provided support for the patients' social and emotional needs.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The practice had invited the Medical Protection Society (MPS) to carry out a patient safety survey to support the practice in the identification of risks to patients. The MPS is a protection organisation for medical, dental and healthcare professionals. The survey covered the key areas of leadership and teamwork; communications; reporting and learning and resourcing and training.

We saw that risks were divided into short, medium and longer term priorities. We saw that risks such as the need to carry out infection control audits had been completed. However, other risks such as the need for all staff to receive training in the safeguarding of vulnerable adults had not been addressed. The practice manager showed us evidence that they were in the process of sourcing this training.

We saw a complaint from a patient that showed a prescribing error had occurred when a message requesting a repeat prescription had been taken from the answer machine. We saw that this had been discussed with the patient participation group (PPG) who felt strongly that they did not want this facility removing. However, a risk assessment had not been completed to demonstrate how the practice would manage the risk of this incident occurring again.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received

training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Most staff we spoke with knew the location of this equipment and records confirmed that it was checked monthly.

Emergency medicines were available in a secure area of the practice and most staff knew of their location. These included medicines 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 were recorded to reduce and manage the risk. Risks identified included power failure, loss of information technology, staff shortage and the loss of domestic services.

A fire risk assessment had been carried out at the practice that included the actions required to maintain fire safety. Records showed that some staff were up to date with fire training. However, fire drills had not been carried out to ensure that staff were aware of how to safely evacuate patients in the event of a fire. An oxygen warning sign was not displayed on the door of the room where the oxygen cylinder was stored. This was required to alert the fire service to the presence of oxygen if a fire were to occur at the practice.

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). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP partners told us they both led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. We spoke with the GP registrar who told us they were provided with training in assessing the needs of patients through weekly education tutorials with the GP partners. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened.

A GP partner showed us Clinical Commissioning Group (CCG) benching marking data that demonstrated the practice was below the regional average for its antibacterial prescribing. We saw that the practice had received an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used in the treatment of heart failure. Following the alert the practice's pharmacy advisor had completed an audit of patient records. The aim of the audit was to ensure that patients with heart failure received the correct medication and treatment. We saw that where medication reviews were required, the pharmacist informed the GP who arranged for a review of the medication with the patient.

With support from the CCG, the practice had identified patients with complex care needs. They told us that there were 71 patients on this list and all of them had a hospital avoidance care plan in place. We were shown the process the practice used to review patients recently discharged from hospital and patients receiving palliative care. We saw minutes from multi-disciplinary meetings confirming that the practice followed 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, care homes, district and palliative care nurses took place to support these vulnerable patients.

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 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, managing child protection alerts, monitoring accident and emergency attendances and medicines management.

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, an audit of patients prescribed a medicine for the treatment of moderate to severe pain had been carried out. The aim of the audit was to monitor that prescriptions for this medicine did not exceed 30 days and that there were clear directions how patients should take the medicines. The results of the audit demonstrated that 22 of the 25 patients who were prescribed this medicine met the criteria. The remaining three patients whose prescriptions did not meet the criteria had received a medication review and their prescriptions amended accordingly. Suggestions on how the prescribing of this medicine could be improved had been made but a repeat audit had not been carried out to demonstrate if these suggestions had been effective.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with asthma had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (the name for a collection of lung diseases, including chronic bronchitis and emphysema).

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. However, clinical and non-clinical responsibilities were not always clearly defined. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and were aware of their roles and responsibilities in carrying this out.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and held quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or above other services in the area. For example, the prescribing of antibiotics.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff had attending mandatory courses identified by the practice such as annual basic life support. We noted a good skill mix among the GPs with both GP partners having additional diplomas in sexual and reproductive medicine, and one GP partner with a diploma in obstetrics and gynaecology. The GPs were up to date with their yearly continuing professional development requirements and had been revalidated. 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 supported staff in accessing training. For example, the practice nurse told us they were being supported to access a nationally recognised course in the management of patients with diabetes. As the practice was a training practice, doctors 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 vaccines and cervical screening. Those with extended roles for example seeing patients with long term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles. The health care assistant and practice nurse offered NHS Health Checks to all its patients aged 40-74. We saw evidence that the staff followed protocols and flow charts in carrying these checks out and that staff had received appropriate training to do this.

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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff. This included 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 three monthly multidisciplinary team meetings to discuss patients with complex care needs, for example those with end of life care needs. These meetings were attended by the practice staff, palliative care nurses and representatives from the care homes. We saw minutes that demonstrated joint decisions about care were made. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice used shared notes to share concerns with the local GP out-of-hours provider. The practice used the Choose and Book system to refer patients for hospital appointments. (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).

Are services effective?

(for example, treatment is effective)

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. 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 clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. However, they had not received formal training in this. 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. For example, in putting do not attempt cardio-pulmonary resuscitation (DNACPR) decisions in place for patients. 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 remains appropriate.

Patients with a learning disability and those with 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). When interviewed, staff gave examples of how patients' best interests were taken into account if they did not have capacity to make a decision. For example, staff showed us the immunisation consent form they used in making best interest decisions for patients who lacked capacity. We saw that there were 13 patients registered with the practice with a learning disability and that six of these patients had an agreed care plan in place. We saw that 85% of patients with a diagnosis of dementia had their care plans reviewed in the last 12 months. 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 patients signed consent forms which were scanned into their records.

Health promotion and prevention

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

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 229 of patients in this age group took up the offer of the health check during 2014 – 2015. We saw that where issues had been identified action had been taken. For example, we saw that patients had been advised to attend for bowel screening, weight management and smoking cessation advice.

The practice had several 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 all patients with a learning disability and six out of 13 had received an annual physical health review. There was a smoking cessation advisor at the practice. We saw that during the period of April 2014 – March 2015, the advisor had supported 18 patients. There was evidence that the advisor had some success as the number of patients who had stopped smoking during this period was five. The practice was pro-active in promoting screening for cancers. During the period of April 2014 – March 2015 the practice had screened 3.4% of their eligible population for chlamydia; 74% of eligible patients for bowel cancer and 62.5% (data from 2013-2014) of eligible patients for breast cancer.

The practice's performance for cervical smear uptake was 81%, which was above the national target of 80%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. The practice had audited the number of inadequate smears. We saw that for June 2013 – May 2014 there was a 12.87% inadequacy smear rate. The practice nurse told us that these mainly occurred when smears were taken on a Friday. As a result of this, the practice nurse had stopped performing smears on Fridays. They told us that their inadequacy smear rate had significantly improved however there was no data to confirm this.

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 all immunisations was in line with or above average for the CCG.

Are services effective?

(for example, treatment is effective)

We saw that there were health promotion leaflets readily available in the patient waiting room. For example, advise about blood cholesterol levels, safe alcohol drinking limits and allergies.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey carried out during January-March 2014 and July-September 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 96% of patients said that their overall experience of the practice was good or very good and that 88% of patients would recommend the practice to someone new to the area. This was significantly above the Clinical Commissioning Group (CCG) regional average of 84% and 72% respectively. The practice was above the CCG regional average for its satisfaction scores on consultations with GPs and nurses. For example, 93% of respondents said the GP, and 96% said the nurse was good at listening to them. This was above the CCG regional average of 83% and 79% respectively. We looked at the results of the Family and Friends test carried out between October 2014 – April 2015. This asked patients if they would recommend their GP practice to their friends and family. We saw that 98.5% of respondents stated that they were likely or very likely to recommend the practice to their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and the majority were positive about the service experienced. Patients told us the staff were helpful, professional, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Six patients told us they experienced problems getting through on the telephone to book appointments but other patients told us the appointment system was easy to use and met their needs. We also spoke with nine 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 practice switchboard was located behind the reception desk but was shielded by glass partitions which helped to keep patient information private. We observed that receptionists actively closed the screens which enabled confidentiality to be maintained. A sign was displayed in the reception area informing patients that they could request to speak with a receptionist in private if they needed 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's zero tolerance for abusive behaviour was clearly displayed in the reception area and on the practice's website.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey carried out during January-March 2014 and July-September 2014 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the survey showed 88% of practice respondents said the GP was good at involving them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these results were above the regional CCG average of 72% and 79% respectively.

Patients we spoke with on the day of our inspection supported these findings. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and

Are services caring?

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 the managers of two care homes where the practice provided care and treatment for older patients. They told us that all the patients living there who were registered with the practice had a care plan in place and received annual health reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNAR CPR) decision had been made regarding a patient, that the patient and their family had been 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.

The practice had carried out annual health checks using a nationally recognised tool for patients with a learning disability. We saw that six out of 13 of these patients had received a follow-up. We saw that the practice also carried out annual health reviews for patients experiencing mental health problems. Patients were signposted to various support groups and voluntary organisations including MIND and SANE for additional support.

Staff told us that translation services were available for patients who did not have English as a first language. We saw that leaflets explaining how the NHS works in the England were available in 21 different languages on the practice's website.

Patient/carer support to cope emotionally with care and treatment

Data from the national patient survey carried out during January-March 2014 and July-September 2014 showed

patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of respondents said the last GP they saw or spoke with was good at treating them with care and concern. This was above the regional average of 77%. 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 recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided care for. To do this, carers were offered the 'flu vaccination and the practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice maintained a list of 11 vulnerable adults and reception staff actively recorded when they were seen. Reception staff telephoned these patients each month if they had not visited the practice, to enquire about their health and wellbeing. Where appropriate, appointments were made for these patients to be reviewed by the GP.

The practice had a system in place to support patients known to them who had experienced a recent bereavement. Information supporting patients in the actions to take when someone dies were clearly displayed on the practice's website. In addition to this, reception staff told us that the GPs telephoned patients known to them who have suffered a bereavement to enquire about their emotional wellbeing. If appropriate, they offered patients an appointment at the practice to be seen by the GP.

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 a high older patient population and patients with long term conditions who required regular blood tests to monitor their conditions. In response to this, the health care assistant had been trained to carry out phlebotomy at the practice to enable patients to reduce the need for patients to travel to their nearest hospital. Phlebotomy is the taking of blood from a vein.

The NHS England Area Team and 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. We saw a practice support visit action plan where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the percentage of patient experiencing poor mental health who had received a health check in the last 12 months. The practice had identified that they had coded this information incorrectly in their electronic computer system and made appropriate changes. We looked at the Quality and Outcomes Framework (QOF) data for 2014 -2015. We saw that following these changes the percentage of these patients who had received an annual health review had significantly improved to 90.2%. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice had also 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. For example, the PPG had identified the need for all staff to wear name badges so patients understood each staff member's role. On the day of the inspection, we observed that staff members all had name badges.

Tackling inequity and promoting equality

Some practice staff had received equality and diversity training through e-learning. A policy to support staff in decisions about equality and diversity was available on the practice's intranet.

The practice was situated on the ground and first floors of the building with services for patients provided on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toys for children to play with were available in the waiting area and there were also baby changing facilities. Accessible toilet facilities were available for all patients attending the practice.

Facilities for patients with disabilities included a disabled parking space; step free access to the front door of the practice; disabled toilets and a hearing loop for patients with a hearing impairment. There was a tarmacked disabled car parking space on the practice's car park. However, the surface of the car park was made from gravel making it difficult to push a wheelchair over the surface to reach the entrance door. The entrance door was heavy and difficult to open. There was no front door bell for patients in wheelchairs to ring to ask for assistance into the practice. We looked at the disabled toilet and saw that the paper hand towels were too high for patients in wheelchairs to reach and the emergency pull cord for patients to pull in the event of a fall was missing.

Staff told us that translation services were available for patients who did not have English as a first language. We saw that leaflets explaining how the NHS works in the England were available in 21 different languages on the practice's website.

The practice provided care and support to several house bound older patients and patients who lived in several care homes. Patients over 75 years of age had a named GP to ensure continuity of care. Patients with learning disabilities were provided with annual health reviews at the practice.

There were no homeless patients registered with the practice but the practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of culture, religion or sexual preference.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Information from the national patient survey showed that 94% of respondents found it easy to get through on the phone and 82% of respondents described their experience of making an appointment as good or very good. These results were above the local CCG average of 75% and 73% respectfully.

Comprehensive information was available to patients about appointments on the practice website and in the practice information leaflet. This included how to arrange urgent appointments and home visits. The practice was open between 8.30am and 6.30pm Monday to Wednesday. It was open between 8.30am and 1pm on Thursdays and 8.30am and 6pm on Fridays.

GP appointments were available between 8.30am to 11.20am each morning. However, on Thursday mornings GP appointments were available until 12pm and appointments started from 8am on Friday mornings. GP appointments were also available between 3pm and 5pm Monday to Friday with the exception of Thursday afternoons when it was closed. Extended hours surgeries for working age patients and school children were offered on Monday evenings between 6.30pm to 7.30pm.

Patients could pre- book appointments over the telephone, face to face or on line through the practice's website. Patients could book appointments up to 28 days in advance. Urgent appointments were available within 48 hours for all patients and on the day appointments were available for children and vulnerable adults. On the day of our inspection we spoke with two parents. They confirmed that when they rang the practice they were always provided with on the day appointments for their child. When the practice was closed patients telephone calls were transferred to Prime Care out of hours service.

Home visits were made to several local care homes to those patients who needed one. We spoke with the managers of two of these care homes who confirmed that the GPs responded to their requests for patients to be seen the same day.

The practice provided a shared care service for patients with substance misuse problems. Shared care is a partnership between the GP and a worker from a substance misuse agency. The GP provided a substitute prescription for the patient and the worker provided support for the patients' social and emotional needs. This enabled patients to be seen at their local GP practice without the stigma of attending a designated substance misuse clinic.

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.

Patients were informed how to complain through the practice information leaflet, the practice's website and the complaints policy was displayed in the waiting room. Some patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw there were records of complaints that had occurred during the last six years and we were able to review these. We looked at seven complaints received in the last 12 months and found they were responded to and dealt with in a timely manner. There was openness and transparency when dealing with them. We saw practice meeting minutes that demonstrated complaints were a regular agenda item. However, it was not always clear that learning from them was shared with staff so they were able to learn and contribute to any improvement action that might have been required.

The practice reviewed complaints annually to detect themes or trends. We looked at their annual complaints review report for April 2014 - March 2015. The practice had identified the importance of communication with patients in responding to the complaints.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision was to improve the health, well-being and lives of patients by working in partnership with them. Their aims and objectives included partnership working with agencies, patients, families and carers; to treat patients with respect; to be a learning organisation and to support staff to do their jobs. A business plan was not in place at the practice. However it was clear from conversations with the GP partners that the development of the service and the needs of the practice population were regularly discussed and reviewed.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to them. We spoke with managers from two care homes for older people who confirmed that the practice had worked in partnership with them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the intranet on any computer within the practice. We looked at 14 of these policies and procedures. Many of the policies had not been reviewed on a regular basis. The practice manager told us that they had identified the need to update the policies as part of their appraisal. They described the actions they would take to meet this need. When policies had been updated, we saw that staff signed a cover sheet to confirm that they had read and understood the updates.

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 one of the GP partners was the lead for safeguarding. We spoke with 10 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 that overall it was performing higher than national standards with a practice value of 95%. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes. For example, QOF data for 2013 – 2014 demonstrated that the practice was below the national average for the percentage of patients who experienced poor mental health who had a care plan in place. The practice had identified that they had coded this information incorrectly in their electronic computer system and made appropriate changes. We looked at the QOF data for 2014 -2015 and saw that following these changes the percentage of these patients who had received an annual health review in the last 12 months had significantly improved to 90.2%.

The practice nurse told us about the monthly educational forum, 'Practice makes Perfect', they attended for practice nurses to share ideas and learning with neighbouring GP practices. They told us that they found this very supportive and enabled them to keep up to date with changes in general practice.

The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of patients prescribed a medicine for the treatment of moderate to severe pain had been completed. The results of the audit demonstrated that 22 out of 25 patients had been provided with prescriptions for this medicine in line with national guidance. The remaining three patients whose prescriptions did not meet the guidance received a medication review and their prescriptions were amended accordingly.

The practice did not hold formal governance meetings but told us that governance issues were discussed at the weekly partners meetings.

Leadership, openness and transparency

Practice meetings for all the staff were held infrequently. However we saw minutes from meetings which demonstrated that separate clinical staff meetings and non-clinical staff meetings were held on a regular basis. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings. The practice had a whistle blowing

Are services well-led?

Good 

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

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. Staff we spoke with knew where to find these policies if required. We saw that the recruitment policy did not reflect legal recruitment standards. Within two working days the practice manager forwarded an updated policy and we saw that this met legal requirements.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the national patient survey, the Friends and Family test, complaints received and their 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 PPG included male and female representatives and had an average attendance of 12 patients who were mainly of retirement age. The PPG had met annually but at the request of the members of the PPG plans had been put in place to start to meet on a quarterly basis. Prior to our inspection we spoke with the chairperson of the PPG who told us that they felt respected by the practice and that their concerns and suggestions were listened to. For example, they told us that the PPG had raised concerns regarding the quality of the notice boards in the waiting room. They told us that the practice had responded to this and improved the way in which information was displayed on them. Observations made during our inspection confirmed this.

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 the management. One member of staff told us that they had asked to attend a recognised course for the management of diabetic patients and that the practice had agreed to support them with this. 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 three staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a GP training practice for GP registrars. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The GP partners were responsible for the induction and overseeing of the training for GP registrars. We spoke with a GP registrar on the day of inspection who told us they felt well supported. They told us they received an educational tutorial once a week and were able to ask the GP partners questions throughout the day.

The practice had completed reviews of significant events and shared the learning from the significant events with staff through practice meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this. However learning from complaints was not always acted upon. For example, we saw a complaint from a patient that showed a prescribing error had occurred when a message requesting a repeat prescription had incorrectly been taken from the answer machine. We saw that this had been discussed with the PPG who felt strongly that they did not want this facility removing. However, a risk assessment had not been completed to demonstrate how the practice would manage the risk of this incident occurring again.

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 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed 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 nursing staff and health care support workers. The registered person did not have a process in place to check that professional registrations for nurses were current and in date. This was in breach of regulations 19 (3)(a) and 19 (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.