

# Drs Taylor Bacon & Wrigley

## 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 conducted a comprehensive announced inspection on 29 June 2015.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. Improvements were needed to ensure that safer recruitment processes were in place and that staff were suitable to carry out the work they were employed for. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings 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, addressed and shared with staff during meetings.
- Risks to patients and staff were assessed and managed. There were risk management plans in which included areas such as premises, medicines handling and administration, infection control and safeguarding vulnerable adults and children.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles. Staff were supervised and supported as needed and any further training needs had been identified and planned for.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. They told us that access to appointments with GPs and nurses was good and that they were happy with the treatments that they received.

# Summary of findings

- Information about services and how to complain was readily available and easy to understand. Complaints were handled and responded to in line with relevant guidelines.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

## Action the provider must take to improve

- The provider must ensure that staff are suitable to carry out the work they were employed to do. Ensure staff are employed with Disclosure and Barring service (DBS) checks and all relevant background checks are carried out including the locum staff.

## Actions the provider should take to improve

- Ensure staff receive training appropriate to their roles, and any training needs are identified, documented and planned, for example, infection control.
- Ensure portable appliance testing (PAT) is carried out by a qualified person for the role who has completed appropriate training. They should complete a risk assessment and ensure documentation is kept for audit purposes.
- Ensure staff personnel files are kept up to date.
- Ensure infection control audits and a Legionella risk assessment are carried out.
- Ensure policies are reviewed regularly and are accessible to all staff.
- Chaperone training should be undertaken by all staff providing this service to patients.

## 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. The recruitment and selection process was not effective. Staff were employed without relevant background checks carried out or documented. The staff had not had disclosure and barring service (DBS) checks. The staff files did not include recruitment references, completed induction programmes, training logs, appraisals or details of the staff members' immunisation status.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong these were investigated to help minimise recurrences. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. Patients including children who were identified as being at risk were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe and sufficient staffing levels were provided to meet patients' needs.

Premises were clean and risks of infection were assessed and managed. We saw evidence of check lists and cleaning schedules but the practice did not have any recent infection control audits. The practice did not have a Legionella policy or risk assessment. The infection control lead had not had extended training for the role however she was supported by a non-clinical member of staff who had completed the training. The practice had a robust infection control policy. Systems were in place to ensure the environment and equipment were clean and staff followed hygienic procedures to minimise risk of infection. The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

**Requires improvement**



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were generally average for the locality and where there were areas for improvement, the practice was proactive in dealing with these. Staff referred to guidance from National Institute for Health and Care Excellence which was used routinely to improve care and treatment outcomes for patients.

**Good**



# Summary of findings

Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical audit cycles were used to monitor treatments and clinical procedures however they were not routinely documented.

Patients' general health was monitored through health screening checks and patients with long-term medical conditions were reviewed annually to assess and monitor their conditions and ensure that the treatment they received was appropriate. The practice provided a range of health promotion advice and sessions including advice on healthy diet and lifestyle choices.

Staff told us they had received the training appropriate to their roles and where further training needs had been identified through mentoring and appraisals, it was planned to meet these needs, for example; the infection control lead needed extended training and the practice manager was in the process of organising it. Staff told us they were supervised and their performance was appraised each year but we did not see evidence of documented appraisals. One member of staff could produce training certificates which she kept in her own personal file. We saw evidence of a training schedule for 2014/2015.

Staff worked with multidisciplinary teams to ensure that patients received effective care and treatment.

## Are services caring?

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice higher than others nationally for several aspects of care, such as how GPs and nurses gave them enough time and explained their care to them, involved them in making decisions and listened to them. 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 accessible and easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received positive remarks on the comment cards about the care patients experienced at the practice, and the patients we spoke with during the inspection confirmed this.

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 NHS England Area Team and the local Clinical Commissioning Group

Good



# Summary of findings

(CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The majority of patients at the practice were in the working age group. The practice had adapted its appointment system to meet the needs of these patients by offering early morning appointments and telephone consultations. Urgent sit and wait clinics were available each morning.

The majority of patients said they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice considered the facilities and made adjustments to meet the needs of patients with mobility difficulties. The practice 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.

## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy and staff knew their responsibilities in relation to this. The ethos within the practice was to provide high quality care and treatment within a friendly and caring environment. Staff demonstrated that this was reflected in the care and treatment provided to patients.

There was a clear leadership structure and staff told us they felt supported by management. Staff said that the practice management were open and responsive to suggestions for improvement. They told us that they were involved in discussions and decision making as to how the practice was managed. There was good teamwork, leadership and commitment to improving the quality of care and patients experiences.

There were named members of staff in lead roles. For example, there were GP leads for safeguarding, diabetes and prescribing. The new infection control lead had not received training appropriate for the role as of the date of the inspection but was supported by a non-clinical member of staff who had completed the training previously. Members of staff we spoke with were all clear about their own roles and responsibilities.

The practice had a number of policies and procedures to support staff and to govern activity, however some were outdated and the policies were not easily accessed by staff. They were unable to tell us where the policies were located.

Good



# Summary of findings

There were systems in place to monitor and improve quality and identify risk but a more robust process to ensure learning takes place should be demonstrated. The practice proactively sought feedback from staff and patients, which it acted on.

# 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

This practice is rated as good for the care of older people. Patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment. The practice identified patients who were at risk of avoidable unplanned hospital admissions. These patients were included on the practice's 'unplanned admissions avoidance' list to alert staff to patients who may be more vulnerable. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice provided a range of health checks for patients aged 75 years and over. Seasonal flu vaccination and shingles vaccination programmes were provided. Flexible appointments were provided, including longer appointments if needed and early morning appointments five days a week. The practice offered a sit and wait clinic for urgent treatment between 9am and 11am each day. Patients aged over 75 years were included on a frailty register and had individualised care plans, which were reviewed by the patients' named GP.

The practice identified patients with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

Good



### People with long term conditions

This practice is rated as good for the care of patients with long term conditions. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual and half yearly reviews of their health and medication to ensure that their treatment remained effective. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Patients had access to early morning appointments from 8am five mornings each week, and daily sit and wait clinics were available for urgent treatments between 9am and 11 am each day. Patients told us they were seen regularly to help them manage their health.

Good





# Summary of findings

## Families, children and young people

Good



The practice is rated as good for the population group of families, children and young people. Appointments could be booked in person or by telephone and up to eight weeks in advance.

Information and advice was available to promote health to women before, during and after pregnancy. A full range of pre-conception, antenatal and postnatal care services was available with the community midwife with fortnightly appointments and clinics. The practice monitored the physical and developmental progress of babies and young children. Appointments were made available outside of school hours wherever possible.

There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed and any issues shared and followed up at monthly multi-disciplinary meetings. GPs and nurses monitored children and young patients who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

Information was available about all childhood immunisations, what they are, and at what age a child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

## Working age people (including those recently retired and students)

Good



The practice is rated as good for the population group 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. Appointments could be booked online, in person or by telephone, up to eight weeks in advance.

Appointments were available from 8am five days each week and until 8pm on a Thursday. A sit and wait clinic was available from 9am to 11am each day for urgent care and treatment.

Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on their website. Nurse led clinics were provided for well patient health

# Summary of findings

checks. When patients required referral to specialist services including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

## People whose circumstances may make them vulnerable

This practice is rated as good for the care of patients living in vulnerable circumstances. The practice had a register of patients who had learning disabilities. All patients with learning disabilities were invited to attend for an annual health check. The practice regularly worked with multidisciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out-of-hours.

Good



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

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required. The practice supports two mental health residential care homes / hospitals, Milton Park and The Priory. The practice offers a weekly sessional visit by one of the GP partners which includes a ward round, regular reviews and meetings with staff about any areas of mutual concern.

Patient referrals were made to appropriate services such as psychiatry and counselling. These included Improving Access to Psychological Therapies (IAPT) and Child and Adolescent Mental Health Services (CAMHS).

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Patients were referred to local counselling sessions where appropriate and patients were provided with information how to self-refer should they wish to receive counselling.

Good



# Summary of findings

## What people who use the service say

We gathered the views of patients from the practice by looking at five CQC comment cards patients had completed. The responses received were positive with all those who completed about the care and treatment they received and the kindness of staff at the practice. All patients who completed comment cards reported that they could be seen on the day and that they did not have to wait long for pre-booked routine appointments.

We also spoke with seven patients at the time of our inspection. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients

were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the NHS England GP patient survey showed that the practice scored in the mid to upper range nationally for satisfaction with the practice. In the survey 82% of patients who participated would recommend the practice. 98% of patients reported satisfaction with the last GP they saw or spoke with and 98% reported satisfaction with the last nurse they saw or spoke with. 306 surveys were sent out and 125 were returned which was a 41% completion rate.

## Areas for improvement

### Action the service **MUST** take to improve

#### The provider must

- Ensure that staff are suitable to carry out the work they were employed to do. Ensure staff are employed with Disclosure and Barring Service (DBS) checks and relevant background checks are carried out including the locum staff.

### Action the service **SHOULD** take to improve

#### The provider should

- Ensure staff receive training appropriate to their roles, and any training needs are identified, documented and planned, for example, infection control.

- Ensure portable appliance testing (PAT) is carried out by a qualified person for the role who has completed appropriate training. They should complete a risk assessment and ensure documentation is kept for audit purposes.
- Ensure staff personnel files are kept up to date.
- Ensure infection control audits and a Legionella risk assessment are carried out.
- Ensure policies are reviewed regularly and are accessible to all staff.
- Chaperone training should be undertaken by all staff providing this service to patients.

# Drs Taylor Bacon & Wrigley

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two CQC inspectors, a GP specialist advisor and a Practice Manager specialist advisor.

### Background to Drs Taylor Bacon & Wrigley

Almond Road Surgery is located on the town of St Neots, which is geographically situated within the borough of Cambridgeshire. The practice provides services for approximately 7100 patients living in the town. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by NHS Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England.

The practice is managed by three GP partners who are supported by clinical staff; one practice nurse and one healthcare assistant. The practice also employs a practice manager and a team of reception, clerical and administrative staff. The practice also employs a cleaner.

The practice is open from 8am to 6pm Monday, Tuesday, Wednesday, Friday and 8am until 8pm Thursdays. A sit and wait clinic is available every week day morning between 9am and 11am. Routine appointments can be pre-booked up to eight weeks in advance in person, by telephone or online. Home visits and telephone consultations are available daily as required.

The out of hours service was provided by urgent care Cambridge (UCC) and could be accessed by contacting the NHS 111 telephone number. The practice sign posted patients to attend the local walk in centre during busy periods and when they were closed.

### Why we carried out this inspection

We inspected Dr's Taylor, Bacon and Wrigley (Almond Road Surgery) as part of our comprehensive inspection programme.

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

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

### How we carried out this inspection

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

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

# Detailed findings

- 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 June 2015. During our visit we spoke with two GP partners, the practice manager, one practice nurse, the phlebotomist / healthcare assistant and reception staff. We spoke with seven patients who used the service. We viewed documents and records relating to the management of the practice. We reviewed five 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 quality in relation to patient safety which included incidents, comments, complaints and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns but were unsure where the policies were held. They told us that the procedures within the practice worked well. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. From the minutes of practice meetings and through discussion with staff we saw that information was shared with staff so as to improve patient safety.

Complaints, accidents and other incidents such as significant events were reviewed and discussed at practice meetings to monitor the practice's safety record and to take action to improve on this where appropriate. Staff we spoke with could give examples of learning or changes to practice, as a result of complaints received or incidents.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Through discussions with staff and a review of records we saw that accidents, significant events and any other safety incidents were investigated. A root cause analysis was carried out to determine where improvements could be made and to identify learning opportunities to prevent reoccurrences. We saw that incidents and significant events were discussed with staff at regular meetings and on an individual basis as needed. Where areas for improvements were identified, these were reviewed to help ensure that

learning was imbedded into the practice. Staff we spoke with could give examples of where practices had changed following investigations of significant events, concerns and complaints.

Staff we spoke with told us that the practice had a 'no blame' culture and said that there was an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Staff told us they had undertaken relevant role specific training on safeguarding adults and children. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice manager did not hold training records but showed training schedules of outstanding training that needed completion and training that had been completed in 2014/2015. The practice had a designated lead for safeguarding vulnerable adults and children, who had oversight for safeguarding and acted as a resource for the practice. We viewed the records of the safeguarding Lead and they had undertaken appropriate safeguarding training, including level 3 safeguarding children training. Staff we spoke with knew who the lead was and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example looked after for children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed at weekly partners meetings and monthly multidisciplinary team meetings. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed, followed up, and appropriate referrals were made as required.

A chaperone policy was in place and details about how to request a chaperone were in the practice leaflet and on the

## Are services safe?

website. (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). The chaperone policy described the clinician's responsibilities for determining when a chaperone would be needed. Where a chaperone was deemed appropriate but unavailable consultations were rescheduled, unless in urgent situations where to do so would adversely impact on the health of the patient. Staff told us that chaperone duties were undertaken by nursing staff and on rare occasions by administration staff. Staff had not undertaken chaperone training. From records viewed we saw that criminal records checks had not been carried out with the Disclosure and Barring Service (DBS) for all staff working at the practice, who worked as chaperones. Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. Patients we spoke with were aware that they could request a chaperone during their consultation, if they chose to.

Patient's individual records were kept on the practice's newly installed electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that staff had undertaken training in the use of the electronic system and were able to use it to record and store information around patient safety and safeguarding vulnerable patients.

### Medicines Management

Medicines were managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in the correct quantities and in date.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directives and evidence that nurses had received appropriate training to administer immunisations and vaccines. A Patient Group Direction (PGD) is a written instruction for the supply and/or administration of a named licensed medicine for a

defined clinical condition. A PGD allows a registered health care professional to administer a prescription only medicine to a group of patients who fit the criteria without them necessarily seeing a prescriber. In general practice, in circumstances where assessment and treatment follows a clearly predictable pattern (for example; where nurses are administering travel or childhood vaccinations) it is obviously practical for the nurses to operate under a PGD.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had robust arrangements for reviewing patients with long term conditions to ensure that the medicines they were prescribed were appropriate and that risks were identified and managed. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Staff told us that where patients who were prescribed medicines on a longer-term basis that they monitored these to ensure that patients were contacted and attended for their regular medication reviews. They told us that letters and text message reminders were sent and follow up calls made as needed.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets, posters and online. Patients could order repeat prescriptions in person, by post or online through the secure clinical electronic system for patients who were registered for online access. Patients we spoke with told us they were given information about any prescribed medicines such as side effects and any contra-indications. They told us that the repeat prescription service worked well and they received their medicines in good time.

We saw from the data we reviewed that the pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing levels.

There was a system in place for the management of high risk medicines such as medicines used in the treatment of terminal and life limiting illnesses, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We saw that these



## Are services safe?

were stored securely and regularly checked. The practice did not hold a stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

### Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients and staff against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with liquid soap, hand gel and paper towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had in place infection control policies and procedures for staff to follow, which enabled them to plan and implement measures for the control of infection. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. All clinical staff told us they had undertaken infection control training but this was not documented in staff files. A training schedule for 2014/2015 showed that two members of staff had completed the training during that period of time but no other training records could be supplied. All practice staff underwent screening for Hepatitis B vaccination and immunity. The screening results were not in the staff files but the practice manager and staff confirmed that all staff including administration staff had been screened and vaccinated. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections). All staff undertook regular hand hygiene training and staff were provided with appropriate personal protective equipment including gloves and aprons. The new infection control lead had not completed additional training for her role. She was supported by the practice manager who had previously attended it with the recently retired infection control lead. We saw evidence that further infection control training was identified and planned for 2015.

The practice employed a cleaner for general cleaning. We saw there were cleaning schedules in place for general and clinical areas. A company came in to do a deep clean periodically. The practice nurses told us they were

responsible for cleaning the treatment room in between patient consultations. Nursing staff and the practice manager told us that regular visual checks were carried out on the premises and equipment to ensure they were clean however these were not regularly recorded. Records we viewed showed that infection control audits had not been carried out recently to test the effectiveness of the general cleaning and infection control procedures within the practice. This was due to the change in infection control lead awaiting additional training. These audits would demonstrate that the practice had systems in place for identifying and managing risks of infections. The practice carried out minor surgical procedures such as joint injections and minor cryotherapy.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales and thermometers were periodically checked and calibrated to ensure accurate results for patients.

We saw records showing that other equipment required for the safe running of the practice, including fire detecting and fire fighting equipment was checked and replaced as required.

Portable electrical equipment was not portable appliance tested (PAT is an examination of electrical appliances and equipment to ensure that they are safe to use) by an external company, however checks were made on the equipment annually by one of the GP partners. The practice did not have a risk assessment for this, a method statement to identify what checks were carried out or any auditable documentation to evidence that the checks had been completed.

### Staffing & Recruitment

The practice had procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting.

We found that the provider's recruitment policy was not consistently followed in practice to ensure that all staff were suitable to carry out the work they were employed to do. The staff files we checked did not contain all the required information. For example, we checked all clinical staff files and they did not include documented criminal records checks through the Disclosure and Barring Service



# Are services safe?

(DBS). All files we checked including clinical and administration staff files, did not hold any proof of identity. Only one file contained written pre-employment references. The provider must carry out relevant checks when they employ staff.

There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us they felt there was usually enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. At the time of our inspection there were two full time equivalent GPs and one part time GP with a practice patient list of just over 7,100 patients. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures or adverse weather conditions).

## Monitoring Safety & Responding to Risk

The practice had a health and safety policy, of which staff were aware but they were unable to say where it was located. They said they would have to ask the practice manager. We saw that a health and safety risk assessment had been carried out to help identify risks to staff and patients.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they were aware of these procedures but were unaware of where the policies were held. A whistleblowing policy was only held by the practice manager therefore making it inaccessible to the staff confidentially. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health issue or crisis.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Emergency medicines and oxygen was available at a designated place within the practice as were 'anaphylaxis kits' (containing medicines to treat severe allergic reaction). All staff asked, knew the location of these medicines. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity and recovery plan to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Some of the risks identified included power failure, adverse weather, incapacity of staff and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw that the fire safety and evacuation procedures were displayed at fire exits and throughout the practice waiting areas and corridors. Fire alarm tests were conducted weekly and details of these were displayed throughout the building. Staff we spoke with were aware of the procedures to follow in the event of a fire or other untoward event which would require the building to be evacuated.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GP and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information and new guidance were made available in information folders and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments.

We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance assessing and treating patients with long term conditions such as asthma and chronic respiratory illnesses were generally in line with that of the local Clinical Commissioning Group (CCG) averages.

The practice GPs and nurse took a lead role in specialist clinical areas such as learning disabilities, diabetes, heart disease and asthma. The practice nurse carried out reviews for patients with long term conditions through pre-booked appointments. This helped the GPs to treat patients with more complex medical conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice had a system for completing clinical audit cycles, a process by which practices can demonstrate on going quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The GP's within the practice had all completed clinical audits.

We looked at the data and information we held about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was generally in line with the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as dementia, learning disabilities and mental health disorders. We saw evidence that the GPs and practice nurse were proactive in following up on patients who had failed to attend appointments and they had made changes to the availability of appointments for these reviews, adding appointments to daily surgery sessions. The practice kept a register of patients who were receiving palliative care treatment and these patients were monitored and care was planned in line with the requirements of these services.

The practice was commissioned for the new enhanced service. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These were childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia, influenza and pneumococcal Immunisations, health checks for learning disability patients, minor surgery, obtaining a patient participation group, remote care monitoring and rotavirus and shingles immunisations.

### Effective staffing

The practice employed staff who were skilled and qualified to perform their roles. We looked at employment files, appraisals and training records for all members of staff. We saw evidence from a training schedule that staff undertook relevant training and that they were appropriately qualified and trained for their roles. We checked that where appropriate clinical staff had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). Locum GP's however were not routinely checked for registration with the GMC or providers list registration by the practice. The clinical staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Staff we spoke with told us that the GP's provided opportunities for learning and that they undertook a range of face-to-face training. The

# Are services effective?

## (for example, treatment is effective)

schedule we viewed confirmed this. All new staff underwent a period of induction to the practice. We saw an induction check list to evidence this, however the practice had none completed from staff files to show us. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices.

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

Staff told us that individual staff performance was assessed and training and development needs were identified through an annual appraisal system, however we saw no completed documentation of this. Staff told us that when they had identified training interests that arrangements had been made to provide suitable courses and opportunities. The practice team made use of clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice and the support that they received. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had dedicated leads for overseeing areas such as safeguarding and diabetes. The practice nurse had undertaken specific training in health promotion and the treatment of minor illness.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the NHS 111 summaries were reviewed and actioned on the day they were received.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients including those with end of life care needs, vulnerable families and children

on the at risk register. Decisions about care planning were documented in a shared care record. We looked at minutes for the last meeting and found that detailed information was recorded, reviewed and shared to ensure that patients received coordinated care, treatment and support.

### Information Sharing

The practice had systems in place to provide staff with the information they needed. The practice had recently introduced a new electronic patient record to coordinate, document and manage patients' care. All staff had undertaken training on the system. GPs and nurses we spoke with told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. These were passed to GPs to review and act on as required. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care, vulnerable patients and those identified as at high risk of unplanned admission to hospital. We saw that treatment records for patients who had used the 'out-of-hours' service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment.

The practice maintained registers for patients with life limiting illnesses, those identified as vulnerable or frail and patients with mental health conditions or those with learning disabilities. GPs and the nurse at the practice worked closely with Macmillan nurses and other agencies that support people with life limiting illnesses. They held a monthly palliative care meeting to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs. Regular monthly multidisciplinary meetings were held to discuss patients' needs.

Staff were alert to the importance of patient confidentiality. The practice had appropriate policies and procedures in place for handling and sharing patient information.

### Consent to care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment. The procedures included information about a patients' right to withdraw consent. GPs and nurses we spoke with had a

# Are services effective?

(for example, treatment is effective)

clear understanding of the practices' consent policies and procedures and told us that they obtained patients' consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children. The nurse we spoke with told us that they obtained parental consent before administering child immunisations and vaccines.

Clinicians demonstrated an understanding of legal requirements when treating children. They understood Gillick competence (Gillick competence is a term used in medical law to decide whether a child 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Staff we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests.

## Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health promotion and healthy lifestyle choices available within the waiting rooms, reception and entrance hall where patients could see and access them. We saw information about domestic violence advice and support was prominently displayed in waiting areas with

helpline numbers and service details. There was information and guidance available on smoking cessation on the practice website as well as chronic illness and travel immunisation advice. There was information available about the local and national help, support and advice services.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Existing patients between 40 and 74 years old who had not needed to attend the practice regularly and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led clinics and pre-booked appointments were available including sexual health, family planning, heart disease prevention, diabetic and asthma clinics.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Data we looked at before the inspection showed that the practice was performing in line with the average of other practices in the area for take up of childhood immunisations. We saw that the GPs and practice nurse were working proactively to follow patients who failed to attend appointments.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

We gathered the views of patients from the practice by looking at the five CQC comment cards that patients had completed and spoke in person with seven patients. The response from patients was positive with all patients reporting that staff at the practice were helpful and good at listening to them. The patients who completed comment cards said they felt the practice provided consistent and excellent care and treatment.

We reviewed the most recent information available from the GP patient survey. We saw that 85% of patients would describe the overall experience of this surgery as good and 99% of patients reporting that they had confidence and trust in the last nurse they saw or spoke with. We also looked at the results of the NHS Friends and Family Test, which patients completed regularly. We saw from the results of these that the practice had scored consistently high in the May 2015 responses. 28 patients participated in the test in May 2015 and 26 said that they would be either extremely likely or likely to recommend the practice to friends and family. Many patients who participated in the test commented very positively about the friendliness of staff and the reported that they were treated with compassion and kindness.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity however were unable to disclose where they were stored either electronically or in paper form. Reception staff told us that where patients wished to speak privately to a receptionist, they were offered the opportunity to be seen in another room. During the inspection we spent time in the reception area. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

There was information in the practice leaflet and online explaining that patients could request a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so. 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a range of anti-discrimination policies and procedures and staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

### **Care planning and involvement in decisions about care and treatment**

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where patients were able to give this. The procedures included information about patients' right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The National GP Patient survey information we reviewed showed that patient's responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example 98% said they had confidence and trust in the last GP they saw or spoke with and 89% felt they had enough time during consultations. Also 98% had confidence and trust in the last nurse they saw or spoke with and 97% saying they had enough time during consultations. These were both higher than the national average.

Patients we spoke with on the day of our inspection told us that 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. They told us that GPs were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a

## Are services caring?

way that they could understand. Patient feedback on the comment cards we received was also positive and each of the five patients who responded told us that they were happy with their involvement in their care and treatment.

The practice identified vulnerable patients and kept a register. The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older patients, those living in care homes and vulnerable at risk patients. This monitoring identified patients most likely to have an unplanned admission to hospital. Where patients were identified as vulnerable, care plans were implemented, which were discussed and reviewed at multidisciplinary team meetings to help ensure that patients had appropriate support systems in place to help reduced unplanned admissions to hospital.

Staff told us that translation services would be made available for patients who did not have English as a first language. The practice had introduced an electronic appointment check-in system, which was set up to reflect the most common languages in the area. Staff had access

to an interpretation and translation service. The practice website held fact sheets to explain the role of UK health services to patients new to the country and who didn't speak English well.

### **Patient/carer support to cope emotionally with care and treatment**

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at the practice or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations who deal with emotional issues such as bereavement.



# 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. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by Clinical Commissioning Group (CCG) targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities.

The facilities and premises coped with the services which were planned and delivered, with sufficient treatment rooms and equipment available.

The appointment system was effective for the various population groups that attended the practice. The working age population were able to obtain an evening appointment Thursdays until 8pm or early mornings from 8am, five days of the week. Routine appointments could be pre-booked up to two months in advance in person, by telephone or online. Longer appointments were available for patients with learning disabilities, those suffering from poor mental health and those with long-term conditions or complex needs. Home visits were available daily for those with limited mobility or otherwise unable to get to the practice.

Vulnerable patients such as those with a drug and alcohol addiction or suffering with poor mental health were signposted to external organisations that could provide support to them.

### Tackling inequity and promoting equality

The practice leaflet promoted diversity and stated that patients would be welcomed without discrimination. Telephone or online translation services could be accessed where necessary. There was no hearing loop installed for those hard of hearing, however staff explained they only had one patient who was deaf and this was dealt with by

the patient bringing someone with them or by staff writing things down, which they felt promoted patient confidentiality. Those hard of hearing were taken into a separate room for confidentiality if needed.

The practice had registers of patients who may be living in vulnerable circumstances and those with learning difficulties, and staff were able to give examples of how these helped them deal sensitively with patients, for instance offering extra support to attend or longer appointments.

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. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

### Access to the service

Patients could make appointments by telephone, calling at the surgery, or online. Repeat prescriptions could be ordered online. The practice had extended its opening hours in response to increased patient numbers, and was open from 8am until 6pm four days a week and 8am to 8pm on a Thursday. This helped patients access the service who worked during the day. Longer appointments were also available with a nurse or GP for patients who needed them and those with long-term conditions. Home visits could be arranged. The practice supported two local mental health care homes / hospitals.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the specific GP of their choice.

# Are services responsive to people's needs?

(for example, to feedback?)

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice via the sit and wait 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.

We saw that information was available to help patients understand the complaints system. The practice manager handled written complaints but all staff were aware of the complaints procedure and would in the first instance attempt to deal with complaints when they occurred. Information on how to complain was contained in the patient leaflet, on the practice website, and was displayed in reception. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the two complaints received in the last 12 months and found they were both satisfactorily handled and dealt with in a timely way.

We looked at a summary of complaints from the previous years, and could see that these had been responded to in a timely manner, and a full investigation undertaken. Details of the ombudsman had been made available if patients were not happy with the outcome of the complaint investigation. This was evidenced by the practice stating the address, telephone number and email address of the ombudsman on their website.

The practice summarised and discussed complaints at practice meetings, or where necessary on a one to one basis with staff members or as part of their appraisal. The practice was able to demonstrate learning and changes as a result of complaints, such as rewriting of practice information or retraining a member of staff, and we saw minutes of meetings where shared learning and action points were discussed.



# 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 and strategy to deliver high quality care and promote good outcomes for patients in an open and friendly environment. The practices' responsibilities to the patient were described in the patient information leaflet and on the practice website.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews and listening to staff and patients.

### Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. There were policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working and in practice. The policies and procedures were clear but were not up to date and accessible to staff. A number of policies and procedures required review and the practice manager was in the process of doing this.

Staff told us that they were aware of their roles and responsibilities within the team. Some members of staff had lead roles these included palliative care, infection control and safeguarding. The lead for infection control had not had additional training but was supported by the practice manager who had received the training alongside the previous infection control lead who had since recently retired from the practice. The infection control lead was new to the post and awaiting the relevant training. During the inspection we found that all other members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. The QOF data for this practice showed it was performing in line with national standards. The practice had completed a limited number of full audit cycles to review, monitor and learn from.

From a review of records including minutes from staff meetings, complaints and significant event recording, we saw that information was regularly reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.

### Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They reported that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held weekly meetings and met more frequently where required to discuss any issues or changes within the practice.

### Practice seeks and acts on feedback from users, public and staff

The practice sought feedback from patients on a regular basis through the Friends and Family Test. We reviewed the results from May 2015 and found that the majority of patients who participated were extremely likely or likely to recommend the practice to their friend and family.

The practice had an active Patient Participation Group (PPG). A PPG is made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. The majority of patients participated to the group virtually by way of email. The PPG were unavailable to speak with us.

The practice had gathered feedback from staff through staff meetings and discussions with staff. 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. The practice had a whistleblowing policy and those we spoke with said that they would feel confident in reporting any concerns to the practice manager.

# Are services well-led?

Good 

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

## Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance.

We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for,

although there was no documented evidence of this. Staff told us that the practice consistently strived to learn and to improve patient's experience and to deliver high quality patient care.

Staff told us that the practice encouraged them to maintain their clinical professional development and that the practice was very supportive of training and they had protected time for learning and personal development.

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	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p><b>How the regulation was not being met.</b></p> <p>The provider did not have an effective recruitment process in place. Staff, including those who acted as chaperones, were employed without relevant background checks being carried out or documented. Proof of identification was not available for all staff which corresponds to regulation 19 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	