

Dr Lldiko Spelt

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.

Summary of findings

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Summary of findings

Overall summary

Dr Ildiko Spelt (The Great Clacton Medical Practice) provides primary medical services to approximately 7700 patients living in the Clacton-on-Sea and surrounding area in Essex.

We found that the practice is caring but improvements were required to ensure that the practice is safe, effective, responsive and well-led.

Services are available for older people (over 75s), people with long-term conditions, mothers, babies, children and young people. There are also services for people in vulnerable circumstances who may have poor access to primary care, people experiencing poor mental health and working age people and those recently retired (aged up to 74).

The practice has had some staffing issues over the last nine months that have affected their performance and governance of systems and processes. A new practice manager was employed in February 2014 and was, at the time of our inspection, undergoing a complete review of the systems and processes in place at the practice.

We found that the practice did not have satisfactory processes in place when employing new staff. The recruitment policy was not being followed and therefore the practice was unable to assure us that staff had been through a robust recruitment process.

Staff were not adequately supported through an effective system of supervision and appraisal. Nursing and other staff were not monitored to assess their competency to carry out their role.

The practice did not have systems in place to assess and monitor the quality of the services they provide, which is contrary to the regulations. There was an absence of a clear approach to clinical and non-clinical audits, although some were taking place. Patients and staff were not asked for their feedback about the services they provide. Incidents, adverse events and complaints were not analysed to identify areas for improvement. There were limited opportunities to discuss areas for improvement and learning at the practice because staff meetings were informal and not used in a structured way.

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Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were required to ensure the service was safe.

Although patients we spoke with told us they felt they received safe care and treatment, we identified that there were areas where the practice could improve.

There was a general absence of systems in place to assess and monitor the services they provided to ensure that patients received safe care and treatment. The practice risk assessment was several years out of date and needed reviewing, and learning from incidents was not taking place.

The practice had a member of staff who was their safeguarding lead and some staff had received training. Those identified as at risk were subject to monitoring but this was not shared with staff across the practice.

Medicines were managed effectively, stored correctly and the stock rotated. Infection control procedures were in place but record keeping was inadequate. Recommendations made as a result of an infection control audit in July 2013 had not been fully actioned.

Staffing levels were satisfactory and changed during periods of fluctuating demand. The procedure for recruiting staff was not robust.

Equipment and medicines for use in the event of a medical emergency were not being maintained effectively. Medical equipment in use at the practice was not being routinely maintained and calibrated. It was unclear what training staff had received in relation to medical emergencies.

Are services effective?

Improvements were required to ensure the service was effective.

The staff recruitment policy was not being followed. Staff files we viewed did not contain documents to confirm that a person was suitably qualified to work at the practice. Staff were not undergoing a formal induction process as outlined in the policy.

Staff appraisals were not effective and nursing staff were not subject to regular supervision to assess their competency, although staff we spoke with told us they felt supported.

Summary of findings

Health promotion information was available at the practice and several different clinics were available for patients who needed extra support to manage their condition. When patients accessed the 'out of hours' service, the outcomes were reflected on patient records.

There was no system in place to monitor and cascade to staff, changes in best practice and clinical guidance.

Are services caring?

The service was caring.

Patients told us that they were treated with dignity and respect and that their privacy was maintained. They thought that all of the staff were kind and caring and they felt involved in the decisions about their care and treatment options.

The practice made use of chaperones wherever possible and information was available to patients about their use.

Patient records were treated confidentially and staff informing people about test results confirmed people's identity discreetly before passing on any information to them.

Patients told us that their consent, either in writing or verbally, was requested prior to receiving care or treatment. Staff were aware of consent guidance including that relating to children or people with learning disabilities.

Are services responsive to people's needs?

Improvements were required to ensure the service was responsive to people's needs.

The practice understood the needs of patients and provided additional support when required. Health promotion literature was available for people to read and reasonable adjustments had been made to ensure disabled and less mobile patients could access the surgery.

Several patients expressed dissatisfaction with the appointment system for a consultation with a doctor. This was not under review at the time of our inspection. Patients were very positive about the nursing team and appointments with them were readily available.

The elderly or those less mobile were able to have home visits whenever necessary and a system was in place so they could obtain repeat prescriptions without the need to attend the surgery.

The provider's complaints policy, although clear and informative, was not being followed. Complaints therefore were not handled effectively.

Summary of findings

Are services well-led?

Improvements were required to ensure the practice was well-led.

Prior to our inspection there had been a lack of visible leadership by the provider who had concentrated on her role as a GP and had left the administration of the practice to others. A new practice manager had been appointed and the provider was now working much closer with them. It was accepted by the provider and manager that more improvement was required.

The new practice manager had been appointed in February 2014. Systems and processes were being reviewed and positive changes made. We recognise that this may take a number of months to achieve but we saw that progress had been made to date.

Staff we spoke with felt better supported since the arrival of the new practice manager and were complimentary about the proposed changes being made.

There was an absence of a clear governance system to regularly assess and monitor the services they provided.

There were no systems in place to obtain the views of patients or staff to enable the practice to develop and make improvements. The Patient Participation Group had reduced to two or three members and was therefore not as effective as it could be. A Patient Participation Group is made up of volunteer patients who meet regularly to discuss how services could improve.

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

Effective arrangements were in place to identify older people who might be vulnerable to abuse and they were recorded on the patient record system.

The practice had considered the safety of their older people and had made reasonable adjustments to the practice to support those with limited mobility.

Patients over 75 had been allocated a named GP and whenever possible they could see a doctor of their choice. Patients told us that they thought consultations were effective and they were involved in the decisions about their care and treatment.

Patients who had difficulty visiting the surgery or who were housebound could receive home visits for consultations and order repeat prescriptions over the telephone. The practice also tried to identify carers and offer them additional support.

Staffing levels and training met the needs of elderly people. Care and treatment they received achieved positive outcomes. Staff were kind, caring and treated elderly people with dignity and respect. Patient confidentiality was maintained. Staff supervision needed to be more robust to ensure that elderly people were receiving safe care and treatment.

Information and support was available for patients requiring palliative care or bereavement support.

There were no systems in place to monitor the quality of the services provided for older people and to identify areas for improvement.

People with long-term conditions

Patients with long term conditions were protected from the risk of abuse because systems were in place to identify concerns and manage them.

Patients with long term conditions were treated with dignity and respect and staff maintained patient confidentiality.

Effective treatment was available for patients through consultations and referrals to specialists. Several clinics and services were available to support patients. The needs of patients were met and they were involved in their care and treatment.

Summary of findings

The appointment system was flexible to accommodate patients who needed to be seen in their own homes because of mobility issues. Repeat prescriptions could be ordered by phone.

Carers were identified and offered support and assistance on financial and legal matters and how to obtain suitable equipment so that people could manage their care in their own home.

Mothers, babies, children and young people

Mothers, babies, children and young persons were protected from abuse because the practice had made suitable arrangements for identifying and supporting those who were vulnerable.

Cervical screening and immunisation programmes were being followed in accordance with national guidance. This was undertaken and monitored effectively by the nursing staff at the practice.

Staff at the practice were aware of consent issues in relation to young children. The consent policy explained this clearly and it was available for staff to refer to.

The working-age population and those recently retired

Patients of working age and recently retired could obtain appointments after working hours on three evenings each week. They had not been asked for their feedback to see if these times met their needs.

Services provided included health checks and cervical screening to identify issues early and to help patients maintain a healthy lifestyle.

People in vulnerable circumstances who may have poor access to primary care

People in vulnerable circumstances were protected against the risk of abuse. A GP had been nominated as the lead for safeguarding and some staff had been trained accordingly.

People with learning disabilities were provided with health checks, support and care advice.

Care and treatment was provided in line with national guidance.

People experiencing poor mental health

Patients with mental health conditions were protected from abuse because systems were in place to identify those at risk and to provide support to protect them.

Staff were aware of the issues relating to consent as they had received training in the Mental Capacity Act 2005. Staff provided support to patients when necessary.

Summary of findings

Steps were being taken to identify people with caring responsibilities for those patients suffering with poor mental health, so they could be offered appropriate support from other agencies.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection to seek their views on the care and treatment provided at the practice. We also reviewed the feedback patients gave to us on patient comment cards that we had left for them to complete prior to our visit.

Most of the comments we received indicated that patients were dissatisfied with the appointment system for consultations with doctors at the practice. We were told that making appointments on the same day involved either queuing at the door or phoning first thing in the morning and often all appointments had been taken. Some patients said that it was also very difficult to pre-book appointments in advance. Patients said that the doctors were very often running late and some had waited between half an hour to an hour to be seen and that this was a regular occurrence. Patients said that they were always able to obtain appointments with nursing staff and these ran on time.

We received mixed views from patients about the quality of the consultations with the doctors. Some said that they

felt listened to, were given adequate time to discuss their treatment and were involved in decisions. Others felt that there could be improvements. All people we spoke with were very happy with the care and treatment provided by the nursing staff.

Patients generally described the staff working at the practice as kind and caring. They were satisfied that they were treated with dignity and respect. They all expressed satisfaction with the way that their confidential information was handled.

We also spoke with two representatives of the Patient Participation Group (PPG), prior to and after the inspection. They told us that meetings were attended by the assistant practice manager and their views were sought. They told us that they had commented about the cleanliness at the practice and that improvements had been made. They also provided feedback about the appointment system and an amended system was trialled but it did not make any appreciable difference.

Areas for improvement

Action the service **MUST** take to improve

The practice must have an effective system in place to regularly monitor and assess the quality of service that people receive. They must seek the views of staff, patients (including persons acting on their behalf) who use the service and staff working at the practice. Risks relating to patients and others must be identified and managed.

The procedures for checking emergency medicines and equipment must be more robustly monitored.

Complaints, comments and views must be considered and incidents analysed to identify improvements.

Robust recruitment procedures must be put in place including the requirement to obtain relevant documentation to evidence that people are suitable for the role.

Staff must be supported in the workplace through clear induction, supervision, appraisal and peer support processes.

Action the service **COULD** take to improve

The provider could oversee all governance activity in relation to the practice.

Dr Lldiko Spelt

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of two CQC inspectors and two specialist advisors, (a GP and a practice manager/qualified nurse) who both had considerable experience of GP practices and their procedures.

Background to Dr Lldiko Spelt

The practice provides services to approximately 7700 patients who live in Clacton-on-Sea, Essex and the surrounding area. The premises are quite small for the number of patients attending there but there are long term plans to move to a more suitable location in the future where there would be opportunities to develop the practice.

The provider, Dr Spelt is supported by two salaried GPs, GP locums when required and a nursing and administration team. A new practice manager joined the practice in February 2014.

The main hours of the practice are Monday to Friday between 8.30am and 6.30pm, with a late evening surgery each Wednesday until 8pm.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Prior to the inspection we reviewed a range of information we held about the practice and spoke with representatives of the Patient Participation Group. We also reviewed information held by the Clinical Commissioning Group and NHS England.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

On 25 June 2014 we carried out an announced inspection of the practice. We looked at the services they provided which are diagnostic and screening, family planning, maternity and midwifery and the treatment of disease, disorder and injury. We also looked at policies, procedures and other documentary evidence.

Detailed findings

As part of the inspection process we spoke with patients, doctors, nurses and administration staff. We also spoke with representatives of the Patient Participation Group (PPG), who are volunteer patients who meet regularly to discuss how services could improve. We also spoke with six

patients for their views on the services provided at the practice and observed the inter-action between staff and patients. We reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

Improvements were required to ensure the service was safe.

Although patients we spoke with told us they felt they received safe care and treatment, we identified that there were areas where the practice could improve.

There was a general absence of systems in place to assess and monitor the services they provided to ensure that patients received safe care and treatment. The practice risk assessment was several years out of date and needed reviewing, and learning from incidents was not taking place.

The practice had a member of staff who was their safeguarding lead and some staff had received training. Those identified as at risk were subject to monitoring but this was not shared with staff across the practice.

Medicines were managed effectively, stored correctly and the stock rotated. Infection control procedures were in place but record keeping was inadequate. Recommendations made as a result of an infection control audit in July 2013 had not been fully actioned.

Staffing levels were satisfactory and changed during periods of fluctuating demand. The procedure for recruiting staff was not robust.

Equipment and medicines for use in the event of a medical emergency were not being maintained effectively. Medical equipment in use at the practice was not being routinely maintained and calibrated. It was unclear what training staff had received in relation to medical emergencies.

Our findings

Safe patient care

There were systems in place to report and record incidents and accidents. This was documented in a policy. Staff we spoke told us they were aware that incidents should be reported to the practice manager or the provider and were encouraged to do so. They told us they rarely received any feedback about adverse incidents or complaints.

There was a general lack of information available to reflect that patient safety was monitored and assessed regularly. There was a lack of any clear and completed audit cycles, patient and staff feedback, health and safety checks and patient safety alerts.

A practice risk assessment had last taken place in 2007. This was not current and required a review. There were no records kept to monitor health and safety issues that affected the premises, patients and staff. The practice manager told us that regular inspections of the premises took place to identify risks, but these were not recorded. We did not find any health and safety concerns on the day of our inspection.

The six patients we spoke with during our inspection told us that they felt safe at the practice. The feedback we received from comment cards did not identify any safety concerns.

Learning from incidents

The practice did not have a process in place to learn from incidents, adverse events or patient safety alerts. There was an absence of regular staff meetings. When they did take place they were on an ad hoc basis and minutes were not taken.

On the days where the practice was closed for the purposes of meetings to undertake staff learning, this was not used to provide feedback to staff and doctors did not attend. There was also no formal agenda. This was confirmed with the provider, practice manager and staff on the day of our inspection.

Safeguarding

Within the practice a GP had been appointed as the safeguarding lead to manage any concerns about vulnerable adults and children. They had received

Are services safe?

specialist training (level 3) and attended relevant meetings with external agencies when time allowed. There was no formal process used to update staff at the practice about safeguarding issues.

We saw an example of where a vulnerable child had been identified during a consultation and appropriate action had been taken. Patients identified as being vulnerable to abuse were recorded on the patient records system and this system would alert staff when they either called or attended the practice.

A patient information leaflet was on display in reception that provided advice to parents to help keep their children safe from abuse. A poster was also displayed on a wall for staff to refer to about the procedure to follow if they became aware of a potential safeguarding issue.

The doctor responsible for safeguarding and the nurses working at the practice had received training in safeguarding children and adults. It was unclear how many non-clinical staff at the practice had also been trained or who should have received such training. We found that some of non-clinical staff we spoke with had undertaken on-line safeguarding training and some had not received any training at all. Staff we spoke with showed an awareness of the different types of abuse and how to recognise it and would refer any concerns to the practice manager or one of the doctors. One member of staff told us they had raised a concern in the past about a person who may have been at risk and was aware of the procedure to follow.

Monitoring safety and responding to risk

We found that staffing levels were monitored to ensure that there was appropriate cover to manage changes in demand, unavailability of staff, bad weather or illness. Locum doctors were booked in advance to ensure that services were maintained when salaried GPs were absent through annual leave, illness or otherwise unavailable.

We noted that the practice had identified the need for an additional full time doctor and had recently been successful in employing one who was due to start in the near future. A new assistant practice manager was also due to be appointed. This reflected that the practice was initiating recruitment to reduce the risk of staff shortages impacting on the quality of care.

The staff we spoke with were aware of the procedures to follow in a medical emergency that either took place in the

surgery or when it was suspected that a patient was in need of more urgent assistance when calling the surgery. A printed guide was displayed in the reception area to support staff if there was a cardiac emergency. The practice manager had not kept detailed records of who had received first aid training but told us that sufficient numbers had been trained.

A fire risk assessment had been undertaken by an external company in May 2014 and some recommendations had been made. At the time of our inspection these were being progressed by the practice manager. A fire safety policy was in place that identified the person responsible in the event of a fire and the frequency of fire drills but these had not yet taken place. We were told by the practice manager that the person named in the policy as having been trained in the use of fire fighting equipment was incorrect. The practice manager told us that staff had received fire safety training and were aware of evacuation procedures.

Medicines management

A system was in place to manage prescriptions and reviews of medicine. A member of staff had been identified as the lead for patient medicine. Patients on repeat prescriptions were reviewed by a GP every six months. Patients were alerted when they were due for a review of their medicines. If patients did not attend for their review this would be followed up staff at the practice to ensure one took place. Where clinical research identified that use of a particular medicine may have side effects, patients currently taking it were identified and asked to attend the practice so that an alternative medicine could be prescribed.

Medicines requiring refrigeration were stored appropriately as soon as they were received at the practice. Fridge temperatures were monitored regularly and records held reflected that they were being maintained at the correct temperatures to ensure the integrity of the medication.

Medicines stored in refrigerators were all in date and rotated regularly to ensure the most recent stock was used first wherever possible.

Cleanliness and infection control

The practice had nominated the practice manager as the lead for infection prevention and control for both clinical and non-clinical areas of the premises. There was an infection control policy in place that identified how the provider would comply with the regulations, to protect staff and patients from the risk of a health care related infection.

Are services safe?

This covered areas such as hand washing, the disposal of clinical waste, general cleaning of the premises, the availability of personal protective equipment and monitoring the procedures for quality purposes.

The last infection prevention control audit was carried out by an independent specialist in July 2013. The report of this audit highlighted several areas of non-compliance and an improvement plan had been suggested. The report was not acted upon until February 2014 when the new practice manager started working at the practice.

Although we were assured that the actions from the report had been implemented a record was not being kept of the dates when this had been achieved. This would provide evidence that areas for improvements were being dealt with and reflect that patient safety concerns were being acted upon in a timely manner.

Patients we spoke with told us they thought the premises, treatment and consultation rooms were clean and hygienic. We also found the premises to be visibly clean. Staff we spoke with told us that improvements had recently been made after a new contract cleaner had been appointed. We saw evidence of cleaning checklists and schedules but records of cleaning were not being kept on a daily basis. The practice manager told us that the cleaning quality was supervised but this had not been recorded although a 'spot check' form was available for use.

Hand washing guidance was being followed and appropriate equipment and signage were in place. Anti-bacterial gel was available for patients to use when visiting the practice. Sharps bins were correctly labelled, signed, dated and sited safely. Recent testing of the water supply indicated that the risk of legionnaire's disease was low. Personal protective equipment was available for staff to use. We were told that blood spillage kits were available for use but they could not be located.

Staff we spoke with were aware of hand washing guidance and their role in preventing the spread of infections. Some staff records contained details of inoculations against hepatitis B but some did not. A contract was in place to remove hazardous waste safely.

Staffing and recruitment

The practice had a recruitment policy that explained the process that would be followed when employing new members of staff. It stated that Disclosure and Barring Service (DBS) checks would be undertaken on staff. This

identifies whether a person has been convicted of certain criminal offences and replaces the Criminal Record Bureau check. It also stated that two references would be taken, identity documents would be required, qualifications and experience would be confirmed and an interview would take place.

Staff recruitment checks were not evident in the personnel files we viewed. Procedures outlined in the policy did not appear to be taking place. We viewed three staff files on the day of our inspection. None of them contained references, proof of identity or documentation that reflected staff were of previous good character to fulfil the role. We also asked whether DBS checks were taken for all prospective new members of staff and were told they were not and that it depended on the role that they were performing. For those staff members who were not subject to a DBS check, a risk assessment had not been carried out. This was also not made clear in the recruitment policy.

We pointed this out to the practice manager on the day of our inspection. As they had only been employed at the practice since February 2014, they could not clarify whether they were actually missing from the files or not taken at all, but agreed that improvements were required to ensure that staff files contained all relevant recruitment documents.

Dealing with Emergencies

The practice had a business continuity plan in place in the event that services could not be carried out as usual. This covered issues such as a serious incident, loss of electricity supply to the premises, adverse weather conditions or other emergency. There was both an electronic and a hard copy available for staff should it be required.

The plan clearly identified what to do in an emergency situation such as an alternative venue that could be used for patient consultations and treatment, the requirement to keep paper records, infection control issues, the storage of vaccines, useful contact numbers and where other support could be obtained. Not all staff we spoke with were aware that the plan was available.

Equipment

Records we viewed reflected that appropriate testing of electrical devices and gas appliances had taken place recently and that they were working effectively.

Other equipment was in use at the premises that required periodic calibration to ensure it was working correctly. We

Are services safe?

were told that this did take place and that the appropriate testing kit was available but there was no protocol in place to advise of the frequency of such tests and no documentary evidence to show that it had taken place. This included blood testing equipment for people on blood thinning medication or those who required accurate information about their blood/sugar levels (diabetics).

Records reflected that emergency equipment and medicines were being checked but on an ad hoc basis.

We found that some emergency medicines were out of date or out of stock and some equipment was beyond the expiry date. We brought this to the attention of the Practice Manager on the day of the inspection and were told that this would be actioned. We found that three adult masks and one child mask, for use with oxygen, were out of date. We noted that there was no system in place to check that the defibrillator was functioning correctly.

Are services effective?

(for example, treatment is effective)

Summary of findings

Improvements were required to ensure the service was effective.

The staff recruitment policy was not being followed. Staff files we viewed did not contain documents to confirm that a person was suitably qualified to work at the practice. Staff were not undergoing a formal induction process as outlined in the policy.

Staff appraisals were not effective and nursing staff were not subject to regular supervision to assess their competency, although staff we spoke with told us they felt supported.

Health promotion information was available at the practice and several different clinics were available for patients who needed extra support to manage their condition. When patients accessed the 'out of hours' service, the outcomes were reflected on patient records.

There was no system in place to monitor and cascade to staff, changes in best practice and clinical guidance.

Our findings

Promoting best practice

Care and treatment was delivered in line with current NICE guidance but there was no system in place to keep up to date with any changes in best practice, except in relation to medicines advice, which was being followed.

From discussions with GPs and nurses we found that they were carrying out comprehensive assessments and care and treatment met people's needs. Staff had access to appropriate equipment to support them in their diagnosis and treatment and were trained in its use. Patients were referred appropriately and supported to 'choose and book' a specialist of their choice.

Where guidance was received about medicine alerts, we found that patients were asked to attend the practice, their treatment was discussed and alternative medicine was offered to them.

GPs, the nursing team and other members of staff we spoke with, displayed awareness of the various types of consent that could be obtained, issues relating to children and those in need of support through mental incapacity. A consent policy was in place for staff to follow but reviews of consent, to ensure that it had been taken appropriately, had not been undertaken.

One of the GPs was identified as the palliative care lead for those patients approaching the end of their lives. They followed the Gold Standards Framework (GSF), which is a recognised multi-agency approach to palliative care. This GP attended regular meetings with external agencies involved in the process, to ensure that patients received consistent quality care.

Management, monitoring and improving outcomes for people

We were told that clinical audits had taken place in the past but the records relating to them had been missing since the previous Practice Manager had left the practice. They were unable to give us the dates these had taken place and what they covered. We were therefore not assured they were taking place. There were no clinical audits undertaken to monitor that positive outcomes for patients had been achieved and that the practice were comparable with other services. Performance information was not made available to staff, patients and the public.

Are services effective?

(for example, treatment is effective)

Performance was not monitored in relation to patient outcomes to enable areas for improvement to be identified.

Staffing

Once accepted for a role at the practice, a formal induction process would follow and a detailed checklist was available for that purpose. This included a new member of staff receiving three performance reviews in the first six months of their employment.

We looked at the files of three members of staff. Each file was lacking in supporting documentation to assure us that the induction procedure was being followed and that it was effective. New members of staff were not subject to the formal induction process outlined in the practice policy. This included the new practice manager.

We discussed these aspects with the practice manager on the day of our inspection who was aware that improvements were required and that they had not had sufficient time to make improvements since their arrival at the practice in February 2014.

We looked at the appraisals for three staff members. Each had been given a form to complete prior to their appraisal for self-assessment purposes and this included whether they had any development or training needs. An appraisal had followed but this was not documented adequately by the person conducting the appraisal. There was no grading of performance, no information about whether objectives had been met or set, whether training requested had been agreed or actioned or whether any development needs had been discussed. In addition the forms in use for staff were different from those described in the appraisal policy. There was also no indication that any formal supervision had taken place.

When we spoke with one of the members of staff whose file we had viewed, we were told that an appraisal had taken place and that the training request had been agreed and actioned.

We also spoke with three GPs on the day of our inspection. Each had received an annual appraisal and appropriate supervision and were not due for revalidation until 2015.

Staff spoken with told us they felt supported at the practice and there was always someone available to willingly supply advice and guidance. Patients spoken with thought that the doctors, nurses and reception staff were all well trained and competent.

Nursing staff told us that they were supported to undertake their continuing professional development (CPD) in order to maintain their skill levels. One member of the nursing team told us that had been supported to undertake further training in the management of diabetes to support patients with this condition. We did not find any arrangements in place to reflect that nursing staff were supervised to monitor their competency.

The practice did not identify what training was required by each person or the frequency of it. Some staff we spoke with had undergone formal training but records held did not reflect that this was being monitored. The practice manager informed us that training did take place but it was not recorded effectively.

Due to the absence of formal staff meetings we were not assured that there was an effective system in place to notify staff where improvements could be made in relation to clinical and operational issues.

Working with other services

One patient spoken with had used the 'out of hours' service on one occasion and this required their hospitalisation for a short period of time. They told us that when they saw a doctor at the practice for a follow-up appointment after being discharged from hospital, the doctor was fully aware of what had happened and of the outcome.

We were told by staff that they did not have a system in place to share information in advance to 'out of hours' providers about patients with complex health needs and who might need to access the service. This would have given the 'out of hours' providers relevant patient history that would have helped them with any clinical assessment to enable them to provide the most appropriate care and treatment. Doctors and administration staff told us that patient notes were received in a timely fashion when patients had reason to call a doctor from the 'out of hours' service. These were supplied by the relevant doctor by 8am the following morning so the practice were aware of the issues affecting their patients.

Another patient commented positively on how the practice had worked with other health care providers effectively.

Are services effective?

(for example, treatment is effective)

They had been referred to a specialist because they suffered from a long term health condition. They told us that when visiting a doctor at the practice for a follow-up appointment, they were aware of the outcome of the specialist consultation and were able to support them in their continued care and treatment.

A GP care adviser visited the practice each week. Their role aims to provide advice and support to patients and carers in a person centred way, linking their needs to health and social care services that are available in the area in which they live.

Health, promotion and prevention

Information was available in the form of leaflets in the waiting room and reception area that provided guidance about health issues such as smoking cessation, safe levels of alcohol consumption and free NHS health checks. These encouraged patients to take an interest in their own health to improve and maintain it. An 'easy read' version of health screening was available for those who might need it.

Health promotion literature was available in the reception and waiting room areas to promote good health. Patients were able to book an appointment with a GP for general health consultations.

The practice website also contained useful information for patients across a range of health issues. This included how they identified carers who may be in need of support and advice on how to obtain benefits, the availability of support groups and managing people's legal affairs.

New patients were required to complete a patient questionnaire about their lifestyle and medical history. They were then offered a health screening consultation with a doctor. This helped to identify opportunities to provide advice on preventing ill health and to encourage them to have a healthy lifestyle.

The practice helped support patients by providing additional services for them. These included a Saturday 'drop-in' clinic for mothers and babies for vaccinations, companionship support for the elderly living alone, a smoking cessation clinic three days per week and a diabetes education programme. In addition those over 65 years of age were provided with information on how to access services providing screening for vulnerability to abdominal aneurysms. An aneurysm is a weakening of an artery in the stomach which could burst and bleed unexpectedly and generally has no symptoms.

Are services caring?

Summary of findings

The service was caring.

Patients told us that they were treated with dignity and respect and that their privacy was maintained. They thought that all of the staff were kind and caring and they felt involved in the decisions about their care and treatment options.

The practice made use of chaperones wherever possible and information was available to patients about their use.

Patient records were treated confidentially and staff informing people about test results confirmed people's identity discreetly before passing on any information to them.

Patients told us that their consent, either in writing or verbally, was requested prior to receiving care or treatment. Staff were aware of consent guidance including that relating to children or people with learning disabilities.

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were treated with dignity and respect by all staff working at the practice and they thought that staff were kind and caring. However a patient survey had not taken place at the practice to fully assess the views from a broader selection of patients.

Staff we spoke with were aware of privacy and dignity issues that affected patients. Although the reception area did not afford much privacy, staff informed us that if a patient wished to discuss something confidential they would be taken to a private room.

Consultation and treatment rooms were clearly marked and doors were lockable. Appropriate equipment was available to protect people's privacy such as a screened area where intimate examinations could take place in private.

A clearly marked sign was available in the waiting room area that informed patients that chaperones were available if they wished to use them. One patient we spoke with was aware of this and would ask for one if needed. When a chaperone was used it was recorded in the patient's record and we were told it was common practice to use one for the more intimate examinations and procedures. A detailed policy was available for staff to follow and information about chaperones was also available on the practice website. This included the role and limitations of the chaperone.

We were told by staff that when they spoke with patients on the phone or referring to them in the practice, it was commonplace to use their patient reference number rather than mentioning them by name. When providing test results in person or over the phone, staff ensured they were talking to the correct person by confirming their identity. Patients spoken with had no concerns about the confidentiality of their information. A policy was available for staff that outlined their responsibilities in this area and a patient confidentiality poster was displayed in the waiting room area.

During our inspection we observed staff talking with patients. They were treated courteously and with respect. Patients told us that they were made to feel comfortable and relaxed.

Are services caring?

Staff understood the different types of religious beliefs and cultures of the patients attending the practice. Written information was available in the provider's policies that explained the different faiths that people followed and what was important to them. This was accessible to all staff and the practice manager had introduced systems to ensure that staff had read and understood them.

Patients approaching the end of their lives and their families were signposted to support services that were available for them to provide relevant guidance and empathy. If requested, bereaved relatives were referred to organisations that provided specialist support from suitably trained staff but this was not offered as a matter of course.

Information was available in the waiting room area that helped patients understand the type of support that was available in the event of bereavement. The practice was not proactive in contacting the relatives of those recently bereaved but would offer support and advise them of services they could access, if they requested it. The practice website contained useful information about the action to take in the event of a bereavement.

Involvement in decisions and consent

A consent policy was available that identified the different types of consent that could be taken. These included written and verbal. It explained legislation in relation to

consent taken from a child or young person (Gillick competence), people with a learning disability or suffering from a mental health disorder. A consent form was used when written consent was required.

Staff were required to read the policy and monitoring was in place to ensure all staff were reading it. Staff we spoke with had a clear understanding of consent issues including knowledge of the Mental Capacity Act 2005.

Patients we spoke with felt involved in the decisions around their care and treatment. One patient told us that they felt listened to, explanations were clear and this helped them to decide on their care and treatment. They told us that their consent was sought before receiving treatment.

We observed staff speaking with patients and they were treated with kindness and respect. Written information was available to patients that described the services available at the practice and what support services they could access. An 'easy to read' leaflet was available for patients who needed it to help them understand health promotion guidance and to attend an appointment to carry out a health check.

Although written literature was not available in different languages, staff were aware of how to obtain interpreting services if required. Information about the practice was available on the website in different languages for patients who had difficulty understanding English.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Improvements were required to ensure the service was responsive to people's needs.

The practice understood the needs of patients and provided additional support when required. Health promotion literature was available for people to read and reasonable adjustments had been made to ensure disabled and less mobile patients could access the surgery.

Several patients expressed dissatisfaction with the appointment system for a consultation with a doctor. This was not under review at the time of our inspection. Patients were very positive about the nursing team and appointments with them were readily available.

The elderly or those less mobile were able to have home visits whenever necessary and a system was in place so they could obtain repeat prescriptions without the need to attend the surgery.

The provider's complaints policy, although clear and informative, was not being followed. Complaints therefore were not handled effectively.

Our findings

Responding to and meeting people's needs

Patients we spoke with told us that the practice responded to their needs and provided them with support.

The practice had several different types of clinics available to support people and meet their needs. These included chronic obstructive pulmonary disease, diabetes management, asthma and coronary heart disease. Additional services available for patients included cervical screening, child immunisations, family planning advice, warfarin monitoring and weight reduction/lifestyle advice.

Elderly patients over 75 were allocated a 'named' GP in line with national guidance. Wherever possible reception staff tried to ensure that this consistency was maintained. Patients' preferences to be seen by a named, male or female doctor were accommodated whenever possible.

The practice had made some reasonable adjustments to support patients with a disability. There was a ramp available at the entrance and an automatic door to help disabled patients access the service. A toilet had been adapted for patients with a physical disability. There was sufficient seating for patients in the waiting room and equipment was provided in sufficient quantities to meet people's needs.

Patients received support in relation to their care and treatment. One diabetic patient told us that they felt supported to understand and manage their condition. They attended weekly appointments with a nurse at the practice for advice and guidance about losing weight. The practice had also arranged for them to attend a day course with their partner to help them understand diabetic issues and how to maintain a healthy lifestyle.

Access to the service

Information was available on the practice website that described how to obtain an appointment with a doctor or a nurse. There was also the opportunity to book routine appointments on-line. For patients who could not attend during the day, evening appointments were available three days per week until 8pm.

There was a practice leaflet in the waiting area for patients to read which gave information on the services provided by the doctors and the nursing team. It informed patients

Are services responsive to people's needs?

(for example, to feedback?)

about repeat prescriptions, the smoking cessation clinic and details about their website. There was no information about how patients could access the 'out of hours' service although this was clear on the website.

A system was in place to support people who required home visits because they were either too ill to get to the surgery, or had limitations with their mobility. The practice used an 'on call' system with their doctors. Each day a doctor was allocated that role and they triaged the urgent appointments and the home visits. This involved providing telephone consultations where appropriate and carrying out home visits if required.

The surgery opened at 8.30 am and patients could attend in person to try and get an appointment with a doctor on the same day. We were told by reception staff that on most days the appointment slots had all been taken by 9am. There were only three to four appointments available each day to enable patients to pre-book appointments. Staff told us that some of these were often released the day before or on the same day if there was a need. There was a facility to remind patients of their appointments by text message.

Staff we spoke with told us that the doctors were often late starting their surgeries arriving 30 minutes after the scheduled start time on many occasions. They also said that patients complained daily about the lack of appointments. Patients we spoke with told us that they were often kept waiting for 30 minutes or more. One patient told us they had waited 50 minutes after their appointment time to see a doctor. Staff generally felt that the availability of appointments met most people's needs.

Information from patients we spoke with and feedback given from comment cards left at the practice, indicated that there were mixed views about the availability of appointments to see doctors. We noted that the practice had responded to feedback from the Patient Participation Group (PPG) in relation to the appointment system and had piloted some changes which they felt did not make any improvements so it was discontinued. The Patient Participation Group is a group of volunteer patients who meet regularly to discuss how services could be improved.

Other than the feedback from the PPG, there was no indication that the practice was reviewing the appointment system for effectiveness or taking the views of patients into account, because the practice was not pro-actively seeking

them. This would enable the practice to identify any issues about the availability of appointments from a wider patient viewpoint and to ensure that the needs of the practice population were met.

Patients we spoke with told us they were generally satisfied with the time taken for consultation with the GPs, were referred to specialists when appropriate and supported to 'choose and book' their preferred consultant. They told us they were very satisfied with the care and treatment provided by the nursing team and the availability of appointments with them.

A phlebotomy service was available at the practice by appointment. This was used for blood testing, monitoring patients on blood thinning medication and those requiring blood/glucose checks for diabetes.

Patients could obtain repeat prescriptions by attending in person or by submitting a written request and 48 hours notice was required. For those patients identified as having more complex needs who were unable to attend the surgery, they were able to telephone the practice or contact them by email, to obtain their repeat medication. The email facility enabled patients to register through the practice website to ensure information remained secure.

Concerns and complaints

The practice had a complaints policy that was clear and informative and identified the person responsible for handling the complaints and how they would offer support to patients if they needed it. It provided information to patients so they could decide whether their complaint was handled formal or informally and it gave details of other organisations that people could contact if they wished to do so.

The policy explained that a written reply would be received within three days of receiving any written complaint and that an outcome should be achieved no later than six months after one was made. The handling of the complaint would involve an investigation, followed by a written report.

When we looked at the record of two complaints, they had not been dealt with as outlined in their policy. Written acknowledgements were not supplied within the timeframe in the policy and it was not clear how the investigation had taken place or whether the matter had been resolved to the satisfaction of the complainant.

Are services responsive to people's needs?

(for example, to feedback?)

The policy stated that an annual review of all complaints would take place but we were told that this had not been undertaken. As there was an absence of any formal staff meetings it was not clear how or whether any learning from these complaints had been cascaded to staff to make improvements in how the service was delivered.

Patients we spoke with on the day of our inspection were unsure of the complaints process but would raise any issues with staff at reception or the practice manager. A complaints leaflet was available to patients. This was not on display but held at reception where staff told us that they would hand it out if it was requested. The complaints procedure was available on the practice website. The content on the website and written complaints leaflet were different from the one in the policy which had recently been reviewed.

The practice had a Patient Participation Group (PPG). This is a group made up of patients who voluntarily come together to offer ideas for improvements about how the services are provided. We spoke with two members of that support group and were told that it had been difficult recruiting volunteers to attend meetings and the support had reduced in recent months to approximately three attendees at each meeting.

We were told that meetings were attended by the deputy practice manager but the GPs or provider did not attend. Minutes were produced and these were displayed in the waiting room for patients to read. The practice website encouraged people to join the PPG and minutes of one meeting held in March 2013 were available to read. This was out of date and did not reflect the other meetings that had taken place.

We were told that feedback had been given to the practice by the PPG about dissatisfaction with the availability of appointments and cleanliness standards. The practice had responded to this by amending the appointment process but it had not made any appreciable difference so the idea was not progressed any further. A new cleaning contractor had been appointed and improvements had been made. One member of the group felt that the practice was not actively trying to recruit volunteers but accepted that it was difficult for patients to give their time.

The practice did not have sufficient systems in place to obtain the views of patients, relatives, carers or those acting in their best interests. Without such a system the practice could not assess the quality of the care they provided in order to identify where improvements could be made.

Are services well-led?

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

Summary of findings

Improvements were required to ensure the practice was well-led.

Prior to our inspection there had been a lack of visible leadership by the provider who had concentrated on her role as a GP and had left the administration of the practice to others. A new practice manager had been appointed and the provider was now working much closer with them. It was accepted by the provider and manager that more improvement was required.

The new practice manager had been appointed in February 2014. Systems and processes were being reviewed and positive changes made. We recognise that this may take a number of months to achieve but we saw that progress had been made to date.

Staff we spoke with felt better supported since the arrival of the new practice manager and were complimentary about the proposed changes being made.

There was an absence of a clear governance system to regularly assess and monitor the services they provided.

There were no systems in place to obtain the views of patients or staff to enable the practice to develop and make improvements. The Patient Participation Group had reduced to two or three members and was therefore not as effective as it could be. A Patient Participation Group is made up of volunteer patients who meet regularly to discuss how services could improve.

Our findings

Leadership and culture

The practice had undergone some staff issues and changes over the last nine months. A new practice manager had been appointed in February 2014. We were told by the practice that there was an absence of general monitoring and assessment of the services they provided, prior to the new manager being appointed.

There was now a more joint working approach between the provider and practice manager towards the overall management of the practice and progress was being made. We have emphasised to the provider that the responsibility for the management of the practice lies with them and to continue working closely with the new manager. This includes monitoring their progress through an effective appraisal process as it was noted that the practice manager had not been through the induction process.

All policies and systems were under review. Many of the policies in place (before the arrival of the new practice manager) had been updated. The practice manager had a monitoring system in place to ensure staff were aware of their content and were working to the practice objectives. We saw evidence that the new practice manager was driving change and although they had been in post a short time, progress had been made.

Staff we spoke with told us that the new practice manager had already had a positive effect on the way the practice was managed and it was much improved. One doctor who used to work at the practice had recently returned as a locum and had written a personal letter to the practice congratulating them on making improvements since he last worked there.

Governance arrangements

Governance arrangements were not effective and there was a lack of systems in place to monitor the quality and safety of the services provided. A governance lead had been appointed within the practice but progress in this area was not due to be started until July 2014.

Other roles had been allocated to individuals who were responsible for them, such as infection control and safeguarding, but there were no reviews of these to see whether risks were managed appropriately and improvements identified.

Are services well-led?

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

The new practice manager was aware of the need to have a governance framework in place to effectively assess and monitor the services provided. This was recognised as an area that needed improving and work was in progress in relation to it but at the time of our inspection this had not yet been completed.

Systems to monitor and improve quality and improvement

There was no formal process in place to identify the types and frequency of audits undertaken to monitor and assess the quality of the clinical and non-clinical services provided at the practice.

An infection control audit did take place in July 2013 but the recommendations made had not been looked at until February 2014 when the new practice manager arrived. At the time of our inspection not all of these had been implemented.

The practice were not members of Urgent Health UK so did not undertake any peer to peer review or external peer review and audit, to ensure that they were meeting appropriate standards and identifying areas for improvement.

The lack of audits taking place meant that the practice could not assure us that policies and procedures were being followed and were effective. Areas for improvement and risks were not being identified.

Patient experience and involvement

The practice leaflet advised patients that their comments and suggestions were welcomed and that a form was available at reception. Feedback was also encouraged on the practice website.

However there was no formal system for obtaining the views of patients across the range of services provided and the practice was not pro-active in obtaining them. There was an absence of patient surveys, or readily available forms to record suggestions. We did see that a patient had written to the practice commenting that the staff were helpful and this was displayed on a notice board in the reception area.

The only form of patient feedback came from the Patient Participation Group (PPG) which involved the views of three to four people only. Since the formation of the PPG many of the volunteers were no longer involved and it had been difficult to recruit new members.

The most recent National Patient Survey reflected that patients were not satisfied with many of the services offered at the practice. The statistics produced from the survey reflected that only a small number of patients would recommend the practice to others. In addition there were many negative comments on the NHS Choices website that were indicators for the need of a review of the services offered to make improvements. These comments had not been taken account of by the practice to identify areas for improvement.

Staff engagement and involvement

The practice did not hold formal meetings with any of their staff. We were told by staff we spoke with that informal meetings did take place but they were irregular and minutes were not taken. Staff felt confident that they could raise issues or provide ideas for improvement but we saw no evidence of this taking place or being recorded.

We spoke with the provider and practice manager who were aware of this and we were told that this had been recognised as an area for improvement and that they were to take place in the future.

Staff spoken with told us that they felt supported. Advice and guidance was available to them when required. They said that there were able to raise any issues or discuss any concerns they had about the practice.

Staff did comment that staff meetings were not formal or used to provide feedback about areas where improvements were required or lessons had been learned.

We looked at a sample of staff appraisals and found no evidence of setting objectives to support the development of practice and working towards a common goal.

Learning and improvement

We found no management systems in place to enable learning and improvement. There was an absence of regular assessment and monitoring of the services they provided. There was no learning shared amongst the staff other than informally, which was not recorded.

Staff meetings did not take place regularly and minutes were not taken. Protected learning time is an opportunity to close the surgery so that staff can get together and discuss patient safety alerts, learning from incidents, concerns and areas for improvement. Neither staff meetings nor protected learning time were being used effectively to drive improvement. When meetings or

Are services well-led?

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

protected learning took place, we were told that the doctors did not have time to attend due to other commitments. There were plans to make this more productive for staff working there.

We found that the GPs were trained effectively. Nursing staff were completing their continuous professional development (CPD) in order to maintain their skills. It was not clear from records what other types of training staff were required to undertake and the frequency of it.

Opportunities were not being taken to improve the services provided and reduce the risk of unsafe care or treatment.

Identification and management of risk

There were no arrangements in place for the regular and on-going assessment of clinical and non-clinical risk areas. The most recent practice risk assessment was dated 2007

and it was in need of bringing up to date. The new practice manager was in the process of systematically reviewing all policies and procedures to ensure they were current and fit for purpose.

There was recognition by the practice that improvements were required and we saw evidence that this was being progressed. Some policies we viewed had been updated in the last two months and a system was in place to ensure staff had read and understood them.

We also saw evidence that where risks had been identified, they were now being actioned and improvements made. Action was now being taken to address infection control issues and a recent fire risk assessment had taken place. This also identified where improvements could be made and this was receiving attention.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Effective arrangements were in place to identify older people who might be vulnerable to abuse and they were recorded on the patient record system.

The practice had considered the safety of their older people and had made reasonable adjustments to the practice to support those with limited mobility.

Patients over 75 had been allocated a named GP and whenever possible they could see a doctor of their choice. Patients told us that they thought consultations were effective and they were involved in the decisions about their care and treatment.

Patients who had difficulty visiting the surgery or who were housebound could receive home visits for consultations and order repeat prescriptions over the telephone. The practice also tried to identify carers and offer them additional support.

Staffing levels and training met the needs of elderly people. Care and treatment they received achieved positive outcomes. Staff were kind, caring and treated elderly people with dignity and respect. Patient confidentiality was maintained. Staff supervision needed to be more robust to ensure that elderly people were receiving safe care and treatment.

Information and support was available for patients requiring palliative care or bereavement support.

There were no systems in place to monitor the quality of the services provided for older people and to identify areas for improvement.

Our findings

The practice had a system for identifying older patients who were at risk of abuse. A safeguarding lead had been appointed within the practice and patients at risk were recorded on a register and monitored. Reviews of these patients took place by the designated lead who attended meetings with partner agencies when available to discuss their care.

The practice had made reasonable adjustments to the premises to accommodate elderly patients who were less physically able than other patients. A ramp and automatic doors were available at the entrance to the practice. This made access easier for wheelchair users. A toilet had also been adapted for patients with a physical disability.

Elderly patients were supported by staff who were kind and caring. Staff respected people's privacy and treated them with dignity and respect. Chaperones were available when required. The practice worked with other support agencies. Carers to the elderly were identified and offered support.

Patients over 75 years old were allocated a 'named' GP and this was accommodated whenever possible. Patients were given a choice of a male or female GP. Staff had received appropriate training to support the needs of the elderly.

Support was available for people in need of palliative care and one of the GPs at the practice assumed responsibility for this service and liaised with external organisations. If a family had suffered a bereavement, referral to support groups were made if requested. The practice website also contained useful bereavement information.

Older patients could receive screening for abdominal aneurysms. People who lived alone were offered information about how to access companionship support.

Repeat prescriptions could be obtained without the need to attend the practice for those people with limited mobility or conditions that left them housebound. Reviews of medication were regularly undertaken and recorded on the patient's record. Elderly patients were offered relevant vaccinations against the flu virus and/or pneumonia.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Patients with long term conditions were protected from the risk of abuse because systems were in place to identify concerns and manage them.

Patients with long term conditions were treated with dignity and respect and staff maintained patient confidentiality.

Effective treatment was available for patients through consultations and referrals to specialists. Several clinics and services were available to support patients. The needs of patients were met and they were involved in their care and treatment.

The appointment system was flexible to accommodate patients who needed to be seen in their own homes because of mobility issues. Repeat prescriptions could be ordered by phone.

Carers were identified and offered support and assistance on financial and legal matters and how to obtain suitable equipment so that people could manage their care in their own home.

Our findings

There were systems in place at the practice to identify patients with long term conditions that might be vulnerable to abuse. Patient records were marked up accordingly so it enabled staff to identify and support them when they attended the practice.

Patients who had long term medical conditions received care and treatment according to NICE national guidelines. They were treated with dignity and respect and were involved in the decisions about their condition.

The practice ran clinics to help monitor and support those patients with long-term conditions. These included those with diabetes, those with chronic pulmonary obstructive disorder, cancer and coronary heart disease. The practice website contained useful information about these clinics. They also provided a phlebotomy service at the practice so patients could have their blood taken locally rather than attending a hospital. This helped support those people requiring regular checks on their warfarin or blood/sugar levels.

The nursing team also supported patients with long term conditions. One nurse spoken with had undertaken advanced diabetes training and another was trained in spirometry to support patients with illnesses that affected their breathing.

Patients who were too ill to attend the surgery could receive home consultations and were able to order their repeat prescriptions by phone or by email. Reviews of their medicines took place six monthly and this was monitored to ensure they took place. Patients with long term conditions and who were vulnerable to infection were offered appropriate vaccinations to maintain their health and wellbeing.

People with long term conditions

The carers for patients with long term conditions were provided with support to access other services and to obtain relevant benefits and legal advice.

There was a general lack of assessing and monitoring the services they provided. Patients were not routinely asked for their views about how the service was managed in relation to their population group and staff ideas for improvement were not sought.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Mothers, babies, children and young persons were protected from abuse because the practice had made suitable arrangements for identifying and supporting those who were vulnerable.

Cervical screening and immunisation programmes were being followed in accordance with national guidance. This was undertaken and monitored effectively by the nursing staff at the practice.

Staff at the practice were aware of consent issues in relation to young children. The consent policy explained this clearly and it was available for staff to refer to.

Our findings

The practice had systems in place to protect mothers, babies, children and young people from abuse. A lead for safeguarding had been appointed to monitor those identified as vulnerable and these were put on a register and patient records marked accordingly. We saw an example of where a vulnerable child had been identified during a consultation and appropriate action had been taken.

Those on the register were not routinely discussed at the practice with other staff because there was a lack of appropriate meetings.

After being registered, new babies went through a structured vaccination programme at various stages of their development. Mothers also received cervical screening at recognised intervals from nurses at the practice.

Vaccines for children and young people were stored correctly and stock was rotated to reduce the risk of them going out of date. Where they were required to be stored in fridges, these were kept at the correct temperatures and records were kept. When vaccines were delivered to the practice, a process was in place to ensure that they were refrigerated as soon as possible after receiving them.

Staff were aware of the need to obtain appropriate parental consent in relation to children. They were also aware of the Gillick competency which covers the ability of older children, under 18 to understand consent issues, without the need for a parent to be present.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Patients of working age and recently retired could obtain appointments after working hours on three evenings each week. They had not been asked for their feedback to see if these times met their needs.

Services provided included health checks and cervical screening to identify issues early and to help patients maintain a healthy lifestyle.

Our findings

Patients of working age were able to attend appointments with a GP on three evenings a week if they wished, although we were told that these appointments times were not readily available. Their views were not obtained by the practice about the availability of appointments so it was unclear whether the system in place met their needs.

Patients were able to access free health checks in order to assess their lifestyle and assess whether measures could be taken to reduce the risk of illness. A blood pressure monitor together with instructions for use was available in the waiting area, prior to a consultation.

Other services available included smoking cessation advice, blood testing, weight loss guidance and cervical smear testing.

Quality assurance processes needed improving to ensure that areas for improvement were identified to ensure patients were receiving effective care and treatment.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

People in vulnerable circumstances were protected against the risk of abuse. A GP had been nominated as the lead for safeguarding and some staff had been trained accordingly.

People with learning disabilities were provided with health checks, support and care advice.

Care and treatment was provided in line with national guidance.

Our findings

The practice identified people in circumstances who were vulnerable to abuse and monitored their well-being. A register was in place at the practice and a safeguarding lead, from within the practice, had been appointed.

Patients on the register were monitored and contact with external organisations took place where necessary. There were no meetings held at the practice to discuss safeguarding issues with staff working there.

Information was available in an 'easy read' format that described the services provided for patients with learning disabilities.

The practice identified vulnerable people with learning disabilities. The patients and/or those providing support to them were written to or called on the telephone and invited to attend for a health check.

The practice provided advice and support to carers of vulnerable patients. A care advisor visited the practice once each week for that purpose. Advice and guidance was given in relation to the support that was available to them including benefits and legal advice.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Patients with mental health conditions were protected from abuse because systems were in place to identify those at risk and to provide support to protect them.

Staff were aware of the issues relating to consent as they had received training in the Mental Capacity Act 2005. Staff provided support to patients when necessary.

Steps were being taken to identify people with caring responsibilities for those patients suffering with poor mental health, so they could be offered appropriate support from other agencies.

Our findings

Patients experiencing poor mental health who were vulnerable to the risk of abuse were identified and monitored by the safeguarding lead at the practice. Although the lead assumed responsibility monitoring those identified there was no feedback to staff or meetings held to discuss the care and treatment of the patient.

Where referrals were required to specialist services patients were supported by staff to select their preferred consultant and referral letters were sent requesting appointments.

Staff were aware of consent issues in relation to patients experiencing poor mental health and where appropriate supported the patient in the decisions made or ensured that they received appropriate advice from a person who was interested in their welfare such as an adult or independent advocate. This was reflected in the practice consent policy.

Patients suffering from mental health issues and/or those providing support to them were written to or called on the telephone and invited to attend for a health check.

A care advisor attended the practice each week to offer appropriate advice and guidance.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010, assessing and monitoring the quality of service provision.</p> <p>People who used the service and others were not protected against the risks of inappropriate care and treatment because the practice did not have an effective system in place to regularly assess and monitor the safety and quality of service and risks to service users and others.</p> <p>Regulation 10(1)(a)(b) and (2)(b)(i)(c)(i)(e)</p>
Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010, supporting workers.</p> <p>Persons employed in carrying on the regulated activity were not supported to enable them to deliver care and treatment to service users safely because of a lack of appropriate training, development, supervision and appraisal.</p> <p>Regulation 23(1)(a)</p>
Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010, requirements relating to workers.</p> <p>The registered person did not operate effective recruitment procedures. There was a lack of documents to prove identity, no evidence of disclosure and barring checks or risk assessments, absence of references, evidence of interview to support competency for the role.</p> <p>Regulation 21(a)(i)(ii)(iii)</p>