Walton Surgery

Quality Report

Vicarage Lane
Walton On The Naze
Clacton
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Date of inspection visit: 16 June 2015
Date of publication: 24/09/2015

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Walton Surgery on 16 June 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective and well-led services. It also required improvement for providing services for all of the population groups. It was good for providing a caring and responsive service.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. There was no audit trail that reflected that improvement action had been taken.
- Risks to patients were assessed and well managed, with the exception of those relating to the management of medicines, medicines alerts, prescription reviews and stocks of emergency medicines. A legionella risk assessment had not been carried out.
- Infection control audits were not being carried out in line with recommended timescales.
- Staff training met the needs of patients but it was unclear to staff which training they were expected to undertake and when it was due.
- All staff undertaking chaperone training had been appropriately trained but disclosure and barring service (DBS) checks had not been undertaken for reception staff caring out these duties.
- Recruitment processes were robust and staff were suitably qualified and skilled.
- Annual appraisals had been undertaken for clinical staff but not for administration staff.
- Data showed patient outcomes were average for the locality but where the Quality and Outcomes Framework was not being used there was no other performance measure in place.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in the decisions about their care and treatment.
- The national GP survey results published in 2015 reflected that patients were satisfied with the majority of the services provided.
- Information about services and how to complain was available and easy to understand.
- The practice had prioritised services for older people and allocated additional resources to home visits and consultations for patients residing in care homes.
- The practice had policies and procedures in place and provided staff with a handbook to support them in understanding how the practice was managed and the standards expected of them.
- The practice had a productive relationship with the patient participation group but had not sought views from patients in the form of a survey or by other means.

The areas where the provider must make improvements are:

- Review the system for managing national patient safety and medicine alerts so that there is an audit trail for action and that audits take place periodically.
- Review the system for the review of repeat prescriptions and medicines that are high risk and ensure that patient records are accurately coded to reflect that blood tests and reviews had taken place.
- Undertake DBS checks for all staff undertaking chaperone duties or record a rationale or risk assessment that makes it clear why one is not necessary.
- Undertake a legionella risk assessment.

In addition the provider should:

- Review the system for the monitoring of emergency medicines.
- Implement the actions identified in the health and safety risk assessment from 2013 and record environmental quality checks when they take place.
- Maintain records to evidence that an induction process has taken place and completed satisfactorily by new members of staff, locum GPs and locum nurses. Ensure all staff receive an annual appraisal and that registration checks their professional bodies take place.
- Ensure that staff training identifies the type and frequency required for the different staff groups and that it is being undertaken.
- Implement a monitoring system to ensure care and treatment is effective for those clinical areas not the subject of monitoring using the Quality and Outcomes Framework.
- Assess and monitor the services provided by obtaining feedback from patients, undertaking clinical and non-clinical audits and infection control audits in line with recommended intervals.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise and report concerns and safety incidents. Staff had been trained in safeguarding children and vulnerable adults. Significant events were recorded, analysed and areas for improvement identified. However, action taken when improvements had been identified had not been recorded to reflect that improvements had taken place. The system for acting on national patient safety and medicine alerts was not robust. There was no audit trail to ensure that the appropriate action had been taken. The system for monitoring repeat prescriptions and high-risk medicines was not robust. The guidance for the frequency of reviews was not being followed and this put patients at risk. The practice was visibly clean and infection control processes were robust. Infection control audits were not being undertaken at the intervals recommended by guidance and a legionella risk assessment had not taken place. Staff used as chaperones had received training to carry out the role. Non-clinical staff acting as chaperones had not undertaken Disclosure and Barring Service checks. Emergency medicines in use at the practice were monitored but contained medicines that had been prescribed to patients. Fridges used for the storage of medicines and vaccines were kept at the required temperatures. Clinical staff were not being monitored to ensure their annual registration with their professional body was current.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. Where they were lower than the national/local average the practice did not have an improvement plan. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical staff had received appraisals but administration staff had not received them. Staff worked with multidisciplinary teams. New staff at the practice were supported in the workplace and received an induction. The practice worked with other services and made referrals in a timely manner. Clinical staff were aware of consent issues including Gillick consent for children under the age of 16. Health prevention and treatment was available for patients and these included child immunisation and flu vaccinations.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Carers were provided with advice and guidance and signposted to external organisations that could offer additional support. Patients told us they were treated with care and concern.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Services were tailored to meet the needs of patients. Consultations were available for patients in their own homes. Residents of care homes received regular visits from GPs and nurses. Emergencies were prioritised and patients seen on the same day wherever possible. Extended hours were available for patients that needed them. Patients were allocated a named GP and could see a GP of their choice whenever available. The practice was suitable for patients who were disabled or with limited mobility. Longer appointments were available for patients who needed extra time with a GP or nurse. The practice listened to the views of the patient participation group and acted on ideas that improved patient experience. Patients rated the GPs, nurses and reception staff highly for caring. Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised and displayed a duty of candour. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and all staff were aware of how their roles linked to it. A number of GPs had left the practice in the last two years and their ratio of GP to patients was high. This had affected their ability to assess and monitor the services they provided. They were aware of a reduction in their Quality and Outcomes Framework performance but had no plan to achieve progress, due to staff shortages. They were actively trying to recruit GPs to the practice. Some systems and processes were not being monitored and assessed effectively and this put patients at risk. Staff felt supported by management and knew who to approach with issues. Staff had ready access to policies and procedures to govern activity, but some were overdue a review. Governance

Summary of findings

meetings were held monthly. The practice did not seek feedback from patients but had an active patient participation group (PPG). Staff meetings took place regularly and learning was disseminated and discussed. Feedback from staff was sought at team meetings, appraisals and informally.

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

Requires improvement

The practice is rated as good for being caring and responsive and this includes this population group. The practice was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Same day, longer appointments, telephone consultations and home visits were available. Appointment availability was flexible and a dedicated GP was available each day to carry out home visits to patients. Nurses undertook visits to patients in care homes. Patients over 75 received an annual health check and had a named GP. Multidisciplinary meetings took place with other healthcare professionals to identify the care and treatment needs of patients. Flu vaccinations were available and patients were contacted if they had not attended the practice. Staff had received safeguarding training so they could identify vulnerable adults.

People with long term conditions

Requires improvement

The practice is rated as good for being caring and responsive and this includes this population group. The practice was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nursing staff had lead roles in chronic disease management and had received appropriate training. A register was in place to monitor patients with long-term conditions. Chronic disease clinics were available for patients to access. The practice undertook regular health reviews. The practice was pro-active in identifying patients with long-term conditions who were due for a review or failed to attend for appointments. Appointment availability was flexible. Patients in need of same day appointments were prioritised on need. Longer appointments and home visits were available. Patients at risk of hospital admission were identified and their condition monitored. The practice worked with other healthcare professionals to meet the needs of patients with complex health needs.

Families, children and young people

Requires improvement

The practice is rated as good for being caring and responsive and this includes this population group. The practice was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice,

Summary of findings

including this population group. The practice provided a range of family, child and adolescent services. Immunisation rates were relatively high for all standard childhood immunisations. GPs and nurses had received appropriate family planning training. Appointments were available outside of school hours and the premises were suitable for children and babies. Staff had received safeguarding training and were aware of the signs of abuse and who to contact. Contraception and sexual health services were available for patients to access. Cytology testing was available and patients were encouraged to attend appointments for screening. Six week baby checks and post-natal examinations took place to ensure young children's health was being monitored effectively. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as good for being caring and responsive and this includes this population group. The practice was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as good for the care of working-age people (including those recently retired and students). Online services were available to book appointments and order repeat prescriptions. Extended opening hours were available through the week. The practice provided health screening for working age people to check on their health. Return to work advice and fitness guidance was available to patients returning to work after illness.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as good for being caring and responsive and this includes this population group. The practice was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Staff had received training to identify patients at risk of abuse and to support patients with learning disabilities. Longer appointments were available if required. Patients could be referred to advocacy services if advice and support was required. The practice held a register of patients with a learning disability and they received an annual health check or sooner if required. The practice worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were signposted to various support groups and voluntary organisations.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as good for being caring and responsive and this includes this population group. The practice was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. A lead GP had been appointed for patients experiencing poor mental health. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients with poor mental health were visited in their own homes and in care homes to assess and monitor their condition. Longer appointments were allocated to patients experiencing poor mental health. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection, comment cards were left with the practice for patients to complete to give their views of the practice, including whether staff were kind and caring and whether their needs were being met.

We reviewed 15 cards that patients had completed. All the comment cards reflected very positive comments about the GPs, nurses and reception staff. Patients said they were treated with dignity and respect, their needs were being met and they were satisfied with the care and treatment they received. One comment card completed by a carer reflected that they had been well supported by the practice and felt that the care and treatment provided met the needs of the patient for whom they were caring. Two comment cards reflected that it was sometimes difficult to get an appointment with a GP or nurse.

We spoke with four patients on the day of our inspection. They told us that they were satisfied with the GP, the nurses and reception staff working at the practice. Three out of the four patients were satisfied with the appointment system but comments reflected that appointments did not run to time. They told us that the GPs and nurses were helpful and staff worked to the best of their ability.

The practice had started the NHS Friends and Family test and patients had submitted completed satisfaction cards for the first three months of the year. The majority of patients that had completed this test expressed that they were either extremely likely or likely to recommend the practice.

Representatives of the patient participation group told us that they met regularly with the practice and were involved in making improvements and they were encouraged to provide feedback on the services provided.

Areas for improvement

Action the service MUST take to improve
Action the provider MUST take to improve:

- Review the system for managing national patient safety and medicine alerts so that there is an audit trail for action and that audits take place periodically.
- Review the system for the review of repeat prescriptions and medicines that are high risk and ensure that patient records are accurately coded to reflect that blood tests and reviews had taken place.
- Undertake DBS checks for all staff undertaking chaperone duties or record a rationale or risk assessment that makes it clear why one is not necessary.
- Undertake a legionella risk assessment.

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Review the system for the monitoring of emergency medicines.
- Implement the actions identified in the health and safety risk assessment from 2013 and record environmental quality checks when they take place.
- Maintain records to evidence that an induction process has taken place and completed satisfactorily by new members of staff, locum GPs and locum nurses. Ensure all staff receive an annual appraisal and that registration checks their professional bodies take place.
- Ensure that staff training identifies the type and frequency required for the different staff groups and that it is being undertaken.
- Implement a monitoring system to ensure care and treatment is effective for those clinical areas not the subject of monitoring using the Quality and Outcomes Framework.
- Assess and monitor the services provided by obtaining feedback from patients, undertaking clinical and non-clinical audits and infection control audits in line with recommended intervals.

Walton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Walton Surgery

The Walton Surgery is located in Walton On The Naze, Clacton, Essex. The practice is situated in a side street off the main high street and there are parking facilities available for patients during surgery hours. The practice is one of 44 GP practices in the North East Essex Clinical Commissioning Group (CCG) area. The practice has a General Medical Services (GMS) contract with the NHS. There are approximately 9100 patients registered at the practice.

There are three GP partners at the practice working a variety of hours. They are supported by a salaried GP with locum GPs attending to carry out surgery sessions when required. There are both male and female GPs at the practice. There are currently four nurse practitioners (one in training), three practice nurses, two health care assistants and a phlebotomist. The clinical staff are supported by a practice manager, an office manager, two performance managers (Quality and Outcomes Framework), a reception manager and a number of receptionists and administration staff. There are a total of 38 staff working at the practice.

The surgery is open Monday, Wednesdays and Thursdays from 8.30am to 6.30pm and they have extended opening hours on Tuesdays and Fridays from 7am to 6.30pm. They are closed at weekends. The practice has opted out of providing 'out of hours' services which is now provided by IC24, part of Care UK Limited. Patients can also contact the non-emergency 111 service to obtain medical advice if necessary.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How we carried out this inspection

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

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

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

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

Detailed findings

These questions therefore formed the framework for the areas we looked at during the inspection.

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 16 June 2015. During our visit we spoke with a range of staff including three GPs, two nurses, the practice manager and the office manager. We also spoke with two members of the administration and support staff, four patients who used the service and three members of the patient participation group. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

Although the practice did have systems in place to analyse some patient safety issues, such as significant events and complaints analysis, there were areas where their processes were not robust. These included national patient safety and medicine alerts and reviews of patients' medicines, including repeat prescriptions.

We found that patients had been put at risk because some key safety areas were not being robustly monitored. These included the monitoring of emergency medicines, patient reviews in relation to the medicines they had been prescribed, managing national patient and medicines alerts, the risk to patients and staff from legionella and undertaking disclosure and barring service checks (DBS) on administration staff carrying out the role of chaperone. We found that the practice, despite experiencing staff shortages, had not prioritised these areas and not fully assessed the impact on the safe care and treatment of their patients.

We did find that staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed and found that learning had been cascaded.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of nine significant events that had occurred since June 2014. They included significant events relating to medicine prescribing, action taken after discharge letters had been received and the referral process for specialist treatment.

We found that the significant events were being recorded accurately, analysed, discussed and changes made to systems and processes to reduce the risk of a reoccurrence. However there was no audit trail that identified the area for improvement and the subsequent action taken.

There was an annual evaluation of significant events to identify trends and themes. They were also discussed at practice meetings held periodically. The minutes we viewed reflected that they had been analysed and improvement areas identified. Where staff had been unable to attend team meetings there was a system in place to provide them with the minutes of the meeting so they could be aware of safety issues.

The system in use for monitoring national patient safety and medicines alerts was not robust and there was no policy or protocol in place for staff to follow. An email about the alerts was received by the practice manager and disseminated to clinical staff, including nurse prescribers, for noting and action. There was no system in place to ensure they had been acted upon or the subject of future monitoring where required.

In relation to low risk medicines, we found that the majority of patient's subject of the alerts had received a medicine review and their records updated. This included assessing the risk to the patient and whether it was safe to continue with the medicine concerned. However we found that a number of patients had been prescribed the medicines after the alert had been received so their system of ongoing monitoring was not effective as they were unaware that this was happening.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding policy in place to support staff working at the practice. The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had appointed the GPs as leads in safeguarding vulnerable adults and children. Relevant staff had received safeguarding training and demonstrated an awareness of the various signs of abuse. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Staff spoken with knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We were told that A&E attendances of children were monitored through discharge letters to identify any safeguarding concerns. There was a system to highlight vulnerable patients on the practice's electronic records; for example children subject to child protection plans.

The practice had a chaperone policy. 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 practice only used trained staff to act as chaperones and this included nursing staff as well as reception staff. Training records reflected that the appropriate training had been received.

Those staff members we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All clinical staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Non-clinical staff carrying out chaperone duties had not received DBS checks. The practice agreed to assess their role to determine if a DBS check was required.

Some staff spoken with on the day of our inspection had not received whistle blowing training but were sufficiently aware of the procedures to follow and who to contact at the practice and externally if necessary. Some staff spoken with were not aware of the procedures to follow.

Medicines management

We looked at the system in place for the review of medicines subject to repeat prescriptions and found that it was not robust. Reviews of medicines can include blood tests to assess whether the medicines remain safe to be prescribed. Some medicines require closer monitoring than others due to the potential for harmful side effects.

We conducted searches on the patient record system for patients on three different types of medicines that were considered to be of higher risk than other medicines and found that a number of patients were beyond their review date by over three months. Some of these medicines required patients to undertake blood tests. We found that this put patients at risk of not receiving safe care and treatment and was a potential significant safety issue. The practice agreed to review their repeat prescription and medicine review system to ensure that all patients requiring a review and blood test had received one and that records had been coded accurately.

We found that those patients on a repeat prescription for low risk medicines were not being reviewed in line with best practice. This recommends that patients only receive six repeat prescriptions prior to a review being undertaken, which may take place in the absence of the patient. Consequently we found that some patients had received repeat prescriptions in excess of 19 occasions without a review. The system in place to monitor repeat prescriptions was not effective. We found that uncollected prescriptions had been reviewed to ensure patients were not at risk without their medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Where nurse practitioners were not trained prescribers, they referred prescriptions to the GPs for signing before being issued to a patient.

The practice held a small number of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. We found that the controlled drugs were being stored safely.

We checked medicines and vaccines stored in the fridges and found they were stored securely, rotated regularly and were in date. Fridge temperatures were being monitored and records reflected that the medicines were being kept at the required temperatures.

We found that the practice was monitoring their prescribing data and patterns to identify areas where they could make financial savings. The practice participated in the prescribing incentive scheme. A prescribing advisor attended the practice to review the prescribing patterns at the practice. They undertook searches on a variety of medicines prescribed to patients to ensure they were appropriate for use or whether there were cheaper, effective alternatives. The reviews reflected that savings had been achieved whilst maintaining the effectiveness of the treatment. The prescribing data available to us for the year end March 2014 reflected that the practice was performing in line with other practices both locally and nationally.

Nursing staff were qualified prescribers and trained to carry out consultations for minor conditions and illnesses. They received regular supervision from the GPs in carrying out this role.

The practice had established a service for patients to pick up their dispensed prescriptions at local pharmacies and had systems in place to monitor how these medicines were collected. Patients collecting medicines were given all the relevant information they required.

Cleanliness and infection control

Requires improvement

Are services safe?

The practice had an infection control policy that had been recently reviewed. It contained details about hand hygiene techniques, decontamination training requirements, the risks posed by hepatitis B and the wearing of personal protective equipment by staff. A member of staff had been nominated as the lead for infection control.

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept, including monitoring the quality of the cleaning. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice was following the Control of Substances Hazardous to Health Regulations 2002 in relation to cleaning equipment and materials.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Infection control audits were not taking place in line with the annual frequency recommended in guidance from the Department of Health. We viewed the most recent one undertaken in 2013. The findings indicated that areas for improvement of a minor nature had been identified. Some had been actioned and some had not. There was no clear audit trail that reflected when improvements had been achieved and a repeat audit had not been undertaken since to evidence that improvements had been maintained.

Training records reflected that few members of staff had received infection control training although some staff had been required to demonstrate correct hand washing techniques.

The practice had not conducted a risk assessment in relation to the risk posed by legionella (a bacterium which can contaminate water systems in buildings) to staff and patients. The practice was carrying out annual water temperature testing to mitigate the risk of legionella but this was not based on any risk identified at the practice.

Equipment

Staff we spoke with told us they had the right equipment and in sufficient quantities to enable them to carry out diagnostic examinations, assessments and treatments. We found that equipment had been tested and maintained regularly and we saw documents and servicing records that confirmed they had been undertaken. All portable electrical equipment was routinely tested and a schedule of testing was in place.

We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included obtaining proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We spoke at length with the three GPs, the practice manager and office manager. They told us that the number of GPs employed at the practice had more or less halved in the last 24 months and despite a recruitment drive, they had not been able to identify GPs willing to work at the practice.

The practice was aware that the number of GPs at the practice was not sufficient for the size of the practice population. Another local practice agreed to lease a branch surgery owned by the practice and some patients voluntarily transferred to that practice, relieving some demands on the service. However we were told that the ratio of patients transferring to this practice was not comparable with the loss of the GPs and this had a cumulative effect on patients and the services provided. The practice remained under resourced with GPs.

In order to deal as affectively as possible with this issue, the practice had made use of locum GPs when they were able and some GPs worked additional hours. However, this had not resolved the GP staffing shortfall.

Staff spoken with said there were usually enough staff to maintain the smooth running of the practice but the shortage of GPs reduced the effectiveness of their services. However there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met

planned staffing requirements. Reception staff spoken with told us that they often covered for each other in holiday periods, sickness or training and that the system worked well.

The practice undertook Disclosure and Barring Service (DBS) checks on all clinical staff before they were employed at the practice. Other staff working at the practice were not required, by the practice, to undergo DBS checks, including reception staff carrying out the role of chaperones.

There was no system in place to regularly monitor the GP and nurse registrations with their professional bodies. We found that these checks had been undertaken when staff first started at the practice but no interim reviews had taken place to check whether their status had changed or expired. This was contrary to their own policy which stated that reviews would be undertaken. No registration checks were made when using locum or agency staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment, but these were not being recorded. The practice had a health and safety policy and health and safety information was displayed for staff to read. There was an identified health and safety representative.

The practice had carried out a health and safety risk assessment in October 2013. That assessment identified improvement areas and an action plan had been implemented. This was still on-going and there was a lack of evidence that reflected that improvements had been actioned.

Arrangements to deal with emergencies and major incidents

The practice had carried out a fire risk assessment in 2013 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. The fire system had been serviced in July 2014 and fire extinguishers were in date.

The practice had arrangements in place to manage emergencies. Records showed appropriate numbers of staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the adult and child pads for use with the automated external defibrillator were within their expiry dates.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. However we did find two types of medicines, for use in an emergency that had been prescribed to named patients. The use of such medicines puts patients at risk because the practice was unable to ensure the integrity and effectiveness of the medicines. The practice was unsure how they had got there but agreed to remove them immediately and replace them and to review their emergency medicines monitoring procedures.

The GPs used their own emergency bag which was used when visiting patients away from the practice. We looked at the medicines in the bag of one of the partner GPs and the locum GP and found they contained appropriate medicines that were in date apart from one medicine that had only recently expired. This was removed from the bag, at the time of our inspection, and we were told that it would be replaced.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, GP locum and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. This was available to them from local information sources and on-line NICE updates. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

Clinical staff specialised in clinical areas such as smoking cessation, diabetes, chronic heart disease, asthma and family planning. Nursing staff at the practice had received training to provide consultations for patients with minor illnesses and conditions and were qualified to prescribe medicines. They supported the GPs with minor illness consultations so that they could concentrate on the patients with more complex health needs. Nursing staff spoken with told us that the GPs were readily available for support and guidance.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice monitored their effectiveness through the use of some of the indicators in the Quality and Outcomes Framework. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We were told that due to staff shortages not all QOF indicators were being monitored.

The practice had identified staff members who were responsible for the monitoring of their performance and they had appointed two QOF managers who had both received training to understand the requirements of the role. They were responsible for reviewing the practice performance across key health care areas. Other support staff at the practice routinely collected Information about people's care and treatment and this information was used to improve care. Staff across the practice had roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

Data available to us for the year end March 2014 reflected that the practice was in line with other practices nationally across most of the clinical areas covered by the elements of QOF they monitored. The practice had achieved maximum QOF points for asthma management, cancer diagnosis and the review and assessment of depression. The practice also monitored the management of patients with diabetes, maintaining a register of patients with learning disabilities, conducting regular case review meetings with patients on the palliative care register and the diagnosis and review of patients with dementia.

The practice had a lead for diabetes and this was one of the GPs supported by a nurse and a health care assistant. We spoke with one of the nurses who specialised in diabetes management. They told us that they were aware of the number of diabetic patients at the practice and meetings were held quarterly with the practice diabetic team. These meetings were minuted and used to discuss diabetes management and the practice performance in relation to QOF targets. We were told that they were aware of their performance targets for the QOF and had achieved them for the year ending March 2015. This has yet to be validated by the monitoring authority. Data available for the year ending March 2014 reflected that they were similar to other practices nationally.

Where the performance of the practice was lower than the national average, the practice did not have an action plan to identify where they could improve. This included monitoring patients with hypertension (raised blood pressure). We were told by the practice that the reason for this was a shortage of staff to identify and then implement a plan.

Requires improvement

Are services effective?

(for example, treatment is effective)

We looked at the latest data for the year end March 2015, that was supplied to us by the practice from their own records. This reflected that improvements had been made in their performance. This data was yet to be validated by the Health and Social Care Information Centre, responsible nationally for confirming practice performance statistics.

Due to staff capacity issues the practice had decided not to adopt the voluntary enhanced service to patients who were frail and at risk of an unplanned hospital admission. This is a service that requires a practice to identify at least 2% of their practice population and to provide on-going reviews of their health and to implement a care and treatment plan to avoid an unplanned hospital admission.

We therefore looked at the system they had in place to identify patients at risk of deteriorating rapidly, regardless of whether they had adopted the enhanced service. We found that there was no risk stratification process in place that identified patients that might deteriorate rapidly. A register was not in use and patients had not been identified by other methods. However data available to us in relation to emergency admissions, up to the year end March 2014, reflected that the practice was in line with other practices nationally.

This applied equally to patients in need of palliative care where the practice had not adopted the enhanced service for these patients due to staff capacity issues. We found that patients were being monitored on an 'as needed' basis. There was a minimal palliative care register and a multidisciplinary meeting with other healthcare professionals had not taken place for over a year. However the data to the year end March 2014 reflected that their performance was in line with other practices nationally. The practice had not yet implemented the Gold Standard Framework for palliative care but intended to do so in the near future.

The practice had undertaken a number of clinical and prescription audits and the findings of these audits had driven change and improved processes for the benefit of patients. These included prescribing rates where financial savings had been made and clinical audits such as the effectiveness of acupuncture treatments.

We looked at the acupuncture audit undertaken in June 2014 which assessed the effectiveness of acupuncture treatments carried out at the practice by one of the GPs. The outcome of this audit identified a 61% satisfaction rate and a reduced need for further pain relief as a result of the successful treatment. This audit was due to be repeated in June 2015.

Another audit that had been undertaken included an annual audit of inadequate cervical smears. This identified only six inadequate samples out of 313 and was an improvement on the previous year. A third audit in January 2015 looked at the number of patients with chronic obstructive pulmonary disorder that suffered an exacerbation episode. There were 54 patients identified and they were all given additional support, guidance and an emergency medicines pack. A second audit has been planned for January 2016.

There had only been one repeat audit and that was in relation to inadequate cervical smear screening. This audit reflected that improvements had been maintained. The practice should extend the number of clinical audits they undertake to ensure their services are effective and these should be repeated to assess their performance over the long term.

The practice had a lead for diabetes and this was one of the GPs supported by a nurse and a health care assistant. We spoke with one of the nurses who specialised in diabetes management. They told us that they were aware of the number of diabetic patients at the practice and meetings were held quarterly with the practice diabetic team. These meetings were minuted and used to discuss diabetes management and the practice performance in relation to QOF targets. We were told that they were aware of their performance targets for the QOF and had achieved them for the year ending March 2015. This has yet to be validated by the monitoring authority. Data available for the year ending March 2014 reflected that they were similar to other practices nationally.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that although staff training was being monitored and recorded, there was no clear training requirement in place that identified the type of training required for the different staff groups and the frequency with which it should be undertaken. Staff had received role specific training in a variety of areas including basic life support (including the

use of a defibrillator), safeguarding and information governance. Some clinical staff had received specialist training in diabetes management, wound care and phlebotomy.

ELearning was a form of training that was available to staff at the practice and this included whistleblowing, infection control and information governance, but it had not been routinely taken up by the staff working there. An example of this was infection control training. This had not been recorded in the documents sent to us and although many of the staff had to demonstrate that they understood hand washing techniques, it was not clear whether they had received any infection control training.

All staff at the practice had job descriptions outlining their roles and responsibilities. We were shown the training records for the past three years and noted that the practice had prioritised safeguarding and first aid training for all of the staff. Many of the staff had also received information governance training relevant to their roles. Clinical staff had received a variety of training that met the needs of the patients. This included wound care management, diabetes and asthma management. A training policy was in place that explained the system in place for staff wishing to obtain further training and development and described that the practice would encourage and support this wherever possible.

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

The practice had an appraisal process and policy but clerical and administration staff spoken with told us that they had not received an appraisal for over two years. This was confirmed by both the practice and reception managers. There was no other system in place that measured their competency or identified their training and development needs.

Nursing staff had received an appraisal and these were up to date. The appraisals included identifying their training and development needs. Staff spoken with told us that this was a two way process involving an interview with a line manager. Staff felt they had received a meaningful appraisal and were supported with training requests wherever possible.

New staff to the practice went through an induction process and this took place over a 12 week period. New staff were supplied with a handbook to support them in this process and they were supervised and offered support and guidance before being allowed to work alone. The staff handbook contained supporting information in relation to the standards expected of staff and details of how the practice ran. This included the appointment system and the complaints process.

We spoke with the newest member of staff at the practice who had only been employed in the last few weeks. They told us that they were currently going through the induction process and receiving training. This included use of the computerised patient record system and being supervised when speaking with patients. They told us that they felt supported and that managers and colleagues were providing appropriate advice and guidance. The process included working through a handbook to familiarise themselves with the way the practice operated.

We were told that there was no formal record to show that new staff had completed their induction process and achieved a satisfactory standard so evidence was not available to confirm an induction had taken place for other staff. We were satisfied though that this member of staff had received effective support and guidance and that the system in place was effective.

The practice made use of locum GPs and nurses. We found that there was a formal induction process for them to follow but records were not being kept to reflect that they had been completed. We spoke with one locum GP on the day of the inspection who told us that they had been through an induction process when they first started working at the practice.

The practice had a policy in place that described the processes to follow in the event of poor performance being identified. A grievance procedure was also in place to support staff.

Working with colleagues and other services

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

complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The information received was allocated to one of the GPs for a clinical input to ensure a follow-up or change of medicines were not required for their patients and then the patient's record was updated by support staff, after noting any comments made by the GPs. There was a system to review a test result if the GP requesting the test was absent from the practice when the result was received. Discharge summaries, out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on in a timely way and their system was effective. All staff we spoke with understood their roles and felt the system in place worked well. We found no backlog on the day of our inspection.

Emergency hospital admission rates for the practice were similar to data for other practices nationally. The practice was not commissioned for the unplanned admissions enhanced service and did not have a process in place to follow up patients discharged from hospital. However this had not adversely affected their performance compared with other practices.

The practice did not hold regular multidisciplinary team meetings to discuss patients with complex needs. There had not been such a meeting with other healthcare professionals in the last 12 months, due to GP staff shortages. We did not find that this had affected the care and treatment of patients and emergency cancer admissions and A&E admissions were in line with other practices nationally.

Information sharing

Staff used a computerised patient record system to coordinate, document and manage patients' care. All staff were trained on the system that enabled scanned paper communications, such as those from hospital, to be saved for future reference.

The practice used electronic systems to communicate with other providers. This included the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had implemented the Summary Care Record for patients who were referred to hospital in an emergency. This record contained key information about a patient including any medicines they were taking, allergies they suffered from and any reactions to medicines they may have had. This was also advertised on the practice website for the information of patients. The Summary Care Record helped other healthcare professionals to obtain immediate access to information about the health of a patient.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

There was a practice policy for documenting consent for specific interventions. A variety of consent forms were available for patients to provide written consent when it was required. These included consent for access to medical records and if a patient wished a third party to received medical information about them, such as the results of blood tests.

The policy also provided guidance about the Gillick competency test. (This is used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). Reception staff spoken with were aware of Gillick competence and told us that children presenting themselves at reception for an appointment, without a parent/guardian, would be referred to one of the clinical staff if they did not wish their parent/guardian to be notified. Clinical staff were aware of their responsibilities in relation to Gillick competency.

Health promotion and prevention

The practice was aware of the strategic objectives of the health and social care needs of the local area and directed their services towards them. This information was used to help focus health promotion activity.

The practice had identified leads for child immunisations and cervical screening and these were the nurse practitioners supported by a health care assistant.

The practice's performance for the cervical screening programme was similar to the national average. There was a system in place to offer reminders for patients who did not attend for their cervical screening test. The practice followed up patients who did not attend.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance to the year end March 2014 was similar to expected for other practices for the majority of immunisations where comparative data was available. Childhood immunisation rates for vaccinations were in line with or above other practices in the local area and in some cases the practice had achieved 100% of their targets. Flu vaccination rates were also in line with other practice locally and nationally.

To keep patients informed about some of the health promotion services they offered, the practice advertised in the local papers and shops, added information to prescription slips and displayed signs in the reception area. These included for flu vaccinations and the clinics they ran for patients with long term conditions.

This promotion also included attendance by the British heart Foundation. On one occasion they ran a stall at the surgery to raise the awareness of heart conditions, such as atrial fibrillation (irregular heart rhythm). We were told that this had identified patients who may have been suffering from this condition and follow-up appointments were then offered with the GPs at the practice.

Patients registering with the practice received a health check with one of the nurse practitioners. The GP was informed of any health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice offered a service to patients who wished to give up smoking. Members of the nursing staff provided information and guidance to support patients and they had received appropriate training.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The reception area was open plan and patients were required to queue away from the reception desk so that patients could approach the desk one at a time to maintain some privacy. A touch screen display was available so patients could check-in when they arrived for their appointment.

The reception desk had a glass partition so that patients could not hear administration staff making telephone calls. The waiting room area was situated away from the reception desk so that the chances of overhearing conversations were reduced. Patients wishing to discuss a private matter or who were upset or distressed could be taken to an empty room so that the matter could be discussed privately.

Consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Staff were supplied with a staff handbook which contained advice and guidance as to how to communicate to patients in a compassionate and dignified way. The emphasis placed on reception staff was to treat patients with courtesy and respect and be helpful and supportive whenever possible. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Staff spoken with were careful to maintain confidentiality when informing patients about their test results. They confirmed their identity by asking a series of questions to ensure they were talking to the correct person, before passing on the details of the result.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from July 2015. The results reflected that;

- 94% of patients found that the receptionists were helpful compared with 86% for the local average and 87% for the national average.
- 89% said the GP was good at listening to them compared with 87% for the local average and 89% for the national average.
- 92% said the nurses were good at listening to them compared with 92% for the local average and 91% for the national average.

Other statistics available reflected that patients felt that the GPs and nurses gave them enough time and listened to them and they were in line with the local and national average.

We spoke with four patients on the day of our inspection. Three patients expressed satisfaction with the GPs, nurses and reception staff. One patient commented that they were less than satisfied with the receptionist staff.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 15 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

The evidence overall reflected that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Care planning and involvement in decisions about care and treatment

Data from the national patient survey from July 2015 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared with the local average of 84% and the national average of 86%.
- 82% said the last GP they saw was good at involving them in decisions about their care compared with the local average of 80% and the national average of 81%.

Good

Are services caring?

- 92% said the last nurse they saw was good at explaining tests and treatments compared with the local average of 90% and the national average of 90%.
- 90% said the last nurse they saw was good at involving them in decisions about their care compared with the local average of 86% and the national average of 85%.

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

Patient/carer support to cope emotionally with care and treatment

A care co-ordinator attended the practice weekly to provide advice and guidance for those people with caring responsibilities. This included providing information about the support networks available to them and how to obtain grants, benefits and mobility support aids. The practice identified those patients with carers and made them aware of this service and invited them to attend the practice.

One of the CQC comment cards we reviewed reflected that a carer was very satisfied with the support provided to them by the practice.

Data from the national patient survey from July 2015 reflected that;

- 85% said the last GP they spoke to was good at treating them with care and concern, compared with the local average of 84% and the national average of 85%.
- 88% said the last nurse they spoke to was good at treating them with care and concern, compared with the local average of 91% and the national average of 90%.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice computerised patient record system alerted staff if a patient was also a carer.

Staff told us that if families had suffered bereavement, they were notified and could offer relatives care and support, including a consultation with the GP. They were referred to support services if required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was aware of their practice population. There were higher than average numbers of elderly patients with long term health conditions and complex health needs registered at the practice. 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.

One such example of this was the high number of home visits that the clinical staff had to make. As a result of this they had a system in place whereby a duty GP and/or nurse practitioner would undertake these visits. Time was made available for this purpose and this included visiting patients in their own homes as well as at a number of care homes in the local area. As a result of an initiative set up in 2010, using nurse practitioners to carry out the majority of these visits, we were told that the practice had won a Pulse Vision Award for innovation for the system they had implemented. Pulse is a publication that supports GPs and provides advice and guidance on a clinical matters.

The practice recognised that due to the difficulties in recruiting GPs they were under resourced and patient demand was increasing. As they were unable to recruit GPs to the practice they had employed qualified nurse practitioners that were also trained as medicine prescribers. This allowed them to provide more consultations to patients and demonstrated that they were being responsive to the needs of their patients. We were told that this had a positive effect of the services they provided but that it did not fully meet the needs of the patient population due to the continued shortage of GPs at the practice.

The practice had their own diabetic clinical team to respond to the needs of their diabetic patients. They reviewed patients suffering from diabetes at least annually and more frequently if a patient was identified as in need of additional support or used insulin for their condition. Diabetic clinics were planned two months ahead and additional appointments were made available if there was a demand for them.

Patients over the age of 75 were allocated a named GP and could see a GP of their choice when they were available. The practice was working towards every patient having a named GP by the end of June 2015.

The practice sought feedback from members of their patient participation group (PPG) and posted minutes of their meetings on the practice website. These minutes also reflected that they monitored social media and the NHS choices website to identify where they might respond to patient feedback. This included posting replies where they felt it necessary.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to their premises so that disabled patients and those with limited mobility could access the service easily. The practice had installed a ramp and supporting rail so that patients with limited mobility or using wheelchairs could enter the premises safely. A toilet for the disabled and those with limited mobility was available for patients. The reception area was spacious and suitable for wheelchair users.

The practice had a number of vulnerable patients at the practice including those with learning disabilities and dementia. Staff had received training to be able to support them when necessary. Longer appointment times were available and this service was made clear on the practice website.

Access to the service

The surgery was open for appointments on Monday, Wednesdays and Thursdays from 8.30am to 6.30pm and they had extended opening hours on Tuesdays and Fridays from 7am to 6.30pm. They closed at weekends. The practice had opted out of providing 'out of hours' services which was now provided by Harmoni, another healthcare provider. Patients could also contact the non-emergency 111 service to obtain medical advice if necessary.

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 directed them to the out-of-hours service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments could be booked with GPs and nurses up to four weeks in advance. Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions

Patients with emergencies were offered a same day appointment with a trained nurse practitioner in their minor illness clinic. This nurse was supported by one of the GPs also on duty if a more serious condition was diagnosed.

A duty GP system operated for home visits and this included those patients living in care homes. Those patients requiring home visits would be referred to the GP on duty, then a decision made as to whether one was required.

Staff spoken with told us that it had been problematic in allocating patients to their choice of GP because of the number of staff changes over the last 12 months. Several GPs had left the practice increasing the ratio of GPs to patients and the increasing need to use locum GPs. The practice was aware of this issue and had recently leased their branch surgery to another practice in the area. This had meant some patients voluntarily transferred to the other practice reducing the patient population size. As a result some improvements in access to a preferred GP had been seen but the practice was aware that this was an ongoing issue.

Staff told us that during peak periods of demand, such as the winter flu season, additional staff were employed on reception duties to take calls from patients requiring appointments.

Data from the national GP patient survey from July 2015 reflected that;

- 49% of patients found it easy to get through to the practice by phone, compared with the local average of 73% and the national average of 7%.
- 75% of patients were happy with the surgery hours, compared with the local average of 73% and the national average of 75%.
- 64% usually waited 15 minutes or less after their appointment time compared with the local average of 59% and the national average of 65%.
- 93% said that the last appointment they got was convenient compared with the local average of 93% and the national average of 92%.
- 73% described their experience of getting an appointment was good compared with the local average of 72% and the national average of 73%.

The practice was aware of the number of patients that were not attending for their appointments. In the past, positive action was taken to reduce their frequency. This included sending out letters to patients to explain the negative effect of not attending for their appointment, on other patients. Due to staff issues this monitoring of the appointment system had been put on hold but the practice recognised that it was an area where improvements could be achieved. Text message reminders were in place and signs were up in reception requesting patients to attend for their appointments.

There was no system in place to obtain feedback from patients about their views of the appointment system, other than the data provided by the national GP patient survey. We were told that there was no action plan in place due to staff capacity issues but there was recognition that improvements were required. We spoke with four patients on the day of our inspection. Two patients were satisfied with the appointment system, one felt that waiting times could be improved and one was dissatisfied.

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 in a practice leaflet displayed in reception. The practice website contained the complaints policy and other organisations that a complainant could refer their issue to if they wished. Staff spoken with were aware of the complaints procedure and were encouraged to resolve the more minor issues.

We looked at 28 complaints received in the last 12 months and found that they had been recorded, analysed and dealt with in a timely way. Where the conclusions indicated that the practice was at fault, an apology and an explanation was offered. We found evidence that the learning from complaints had been acted upon and systems changed. The staff guide, issued to all employees, emphasised the need to offer an apology and an explanation to patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

that found it necessary to complain. This was in line with the new 'duty of candour' regulation that puts the onus on the practice to offer apologies and explanations where relevant.

The practice did not review complaints annually to detect themes or trends but there was a system in place to discuss the learning from complaints with staff working at the practice. Learning took place at team meetings and informally. Staff were encouraged to identify where improvements could be made.

Are services well-led?

Requires improvement

(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 statement of purpose and their most up to date version was sent to us prior to the day of the inspection. Their aims and objectives were to the best quality, comprehensive healthcare for their patients, to provide a positive, employment friendly approach and to learn and incorporate best practice to deliver high quality healthcare.

The practice was aware that their performance in relation to the Quality and Outcomes Framework required improvement. However we were told that they did not have a strategy or business plan in place to work towards the required improvements. Due to capacity issues they had decided not to adopt some of the voluntary additional services that were available to them that offered financial incentives if targets were achieved.

We were told that an area of focus for the practice was to recruit more GPs, with a long term vision of providing additional services. It was recognised that the practice was working under considerable pressure to meet the needs of their patients.

Staff spoken with were aware of the vision of the practice and their role in achieving it. Their job descriptions were linked to the practice vision and they told us they were kept informed about all issues affecting the practice and future planning.

Governance arrangements

Overall our inspection identified a number of issues that reflected that systems and processes in relation to good governance were not effective. This included monitoring and assessing the quality of the services provided and assessing, monitoring and mitigating the risks to the health, safety and welfare of patients at the practice.

The specific areas identified that were ineffective were medicines management, action taken as a result of significant event analysis, the frequency of infection control audits, responding to patient safety and medicine alerts, recruitment procedures, appraisal and induction processes and improving outcomes for patients.

The leadership structure at the practice included identifying named members of staff in lead roles. There was a lead for governance, safeguarding, asthma and diabetes management. Most members of staff had received information governance training. Staff spoken with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were readily available to support staff. We looked at a number of these policies and the majority of them had been reviewed in January 2015. Some had gone beyond the review dates set by the practice but we recognised the staffing pressures affecting this practice and in the circumstances this was acceptable. Policies in place included infection control, medicines protocols, confidentiality, and data protection.

Staff spoken with were aware of the location of the policies. They were provided with a staff guide that included the policies in place at the practice. This guide also provided them with information about the general day to day running of the practice. Information within this guide included the appointment system, the repeat prescription process and guidance in relation to the patient computerised record system.

The practice had appointed staff as responsible for monitoring performance of the practice in relation to the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed that it was generally performing in line with national standards. We were told that due to staff shortages, there was no action plan in relation to areas of underperformance for the QOF.

The practice held monthly staff meetings where governance, practice and other issues were discussed. We viewed the minutes of these meetings and found that they had been used to cascade learning from significant events, safety issues and complaints. Several different types of meetings took place at the practice including partners meetings, clinical meetings and clerical staff meetings. There was also a full staff meeting help periodically. At each of these meetings a representative of the different staff groups were present. This enabled continuity and effective communication across all staff members.

Are services well-led?

Requires improvement

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

The practice had carried out a number of audits in the last two years. We were told that the shortage of GPs at the practice meant that clinical audits could not take place as often as they would have liked. Those that had taken place were driven by GP appraisals where an audit formed part of that process. We found that clinical audits had taken place in addition to prescribing initiatives to reduce costs where they were able. Only one audit had been through a repeat cycle to ensure performance was being maintained.

The practice identified, recorded and managed risks and a health and safety risk assessment had been undertaken in October 2013. We were told that the practice was undertaking environmental checks of the building but these were not being recorded.

Leadership, openness and transparency

Staff spoken with told us that the partners in the practice were visible, approachable and always took time to listen to their colleagues. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners and practice manager encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice did not undertake their own patient survey and there was no other system in place to obtain the views of patients other than the recently implemented NHS Friends and Family test and the national GP patient survey.

Data from the national GP patient survey from July 2015 reflected that 70% of patients would recommend the practice to someone new in the area and 83% described their experience at the surgery as good. These were both consistent with national and local averages. However in the absence of their own patient survey, the practice was not reviewing their feedback results from the national GP survey to see if there were any areas that needed addressing. We compared statistics with the January 2015 and the July 2015 results and found that in the majority of areas measured, the satisfaction rates had improved. However they were considerably below the national and local average in relation to satisfaction rates in relation to patients being able to speak with a GP of their choice and getting through to the practice by phone.

The results of the NHS Friends and Family test for the first four months of the year reflected that the majority of patients were either extremely likely or likely to recommend the practice.

The practice encouraged and gathered feedback from patients through the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice website contained details of how patients could join the PPG and the role it played. It also encouraged patients who were unable to attend meetings, to provide feedback via email as part of a virtual group.

The practice posted minutes of meetings and newsletters on their website. The minutes we viewed reflected that members of the PPG were being consulted about their improvement ideas. The practice also monitored social media comments to identify patient feedback. The newsletters explained to patients any developments that were planned new ideas being considered.

On the day of the inspection we met three members of the PPG. They explained that they met monthly with representatives of the practice where their views were sought. They were very positive about the role they played and told us they felt engaged with the practice.

Staff told us that they were encouraged to provide feedback at appraisals, team meetings and informally. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved in the practice to improve outcomes for patients.

Management lead through learning and improvement

Nurses and healthcare assistants working at the practice were supported to maintain their clinical professional development through training and mentoring. As clerical staff appraisals had not taken place, we did not see evidence that they were being supported through the appraisal process to identify their training and development needs. However clerical staff spoken with told us that they felt supported and part of a team.

Are services well-led?

Requires improvement

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

Significant events, safety incidents and complaints were all analysed and investigated and where areas for improvement or learning had been identified, this was cascaded to staff at team meetings and informally.

Clinical and prescribing audits had taken place and the analysis of these identified where the practice could improve.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 – Good governance How the regulation was not being met: The practice did not have an effective system in place to assess, monitor and mitigate the risks to patients in relation to; 1. The proper and safe management of medicines in relation to the management of national patient safety and medicines alerts. They were not being dealt with effectively. There was no audit trail or monitoring to ensure that appropriate action had been taken, including ongoing audit and monitoring of patients subject to the medicine alerts. 2. Patients that had been prescribed high-risk medicines were not being effectively reviewed, including blood tests where required, to properly assess the risks to them of the use of such medicines. 3. Patients on low-risk repeat prescriptions were not being reviewed in line with published guidance. 4. Non-clinical staff had not undertaken a disclosure and barring service check to carry out the role of chaperone and a risk assessment was not in place outlining why this was unnecessary. 5. The practice had not undertaken a legionella risk assessment. Regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014