Dr R Anderson and Dr M Ahmed

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of the practice of Dr R Anderson and Dr M Ahmed. The practice is registered with the Care Quality Commission to provide primary care services. We undertook a planned, comprehensive inspection on 14 October 2014 and spoke with two GPs, the nurse practitioner, two nurses and other staff including the practice manager.

The practice required some improvements and was rated as requiring improvement overall.

Our key findings were:

- Staff understood their responsibilities to raise concerns, and reported incidents and near misses. When things went wrong reviews and investigations were carried out. Out of date medication and equipment was found at the practice and there was no system in place to ensure that all of the medical equipment used by GPs was within its expiry date. The cleaner, who was not directly employed by the practice, had access to the medicines and blank prescriptions as they entered the premises when other staff had gone home. There was no system in place to check the amount of medicines or blank prescriptions at the practice.
- Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was used routinely. Staff had mostly received training appropriate to their roles. Staff appraisals and personal development plans were up to date.
- The majority of patients said they were treated with compassion, dignity and respect. However the practice had a below average score on the national GP patient survey for receptionists being helpful. We observed breaches of confidentiality at the reception desk. The privacy of patients having intimate examinations was not always respected and chaperone arrangements were not consistent.
- Although the patient participation group (PPG) had carried out a patient survey this did not focus on the needs of their local population, or ask questions about

Summary of findings

how the service could be improved. Patients told us it was difficult to access an on–the-day appointment with some telling us they had to wait up to a month to see a GP. The appointment system was not monitored so the practice was not aware of the difficulties faced by patients.

- The practice had a statement of purpose but this was a short hand written document. Staff were not aware of its existence and we saw no evidence of the practice having a set of values. The PPG carried out surveys but we saw no evidence their views were representative of the patient population.

There were areas of practice where the provider needed to make improvements.

Importantly, the provider must:

- The provider must ensure there is an effective system to ensure an appropriate standard of cleanliness and hygiene were maintained throughout the practice was not in place. The provider is failing to meet Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must ensure there is an effective system to record what medicines are held at the practice and manage the disposal of medicines returned by patients. Blanks prescriptions must be kept in a secure manner. The provider is failing to meet Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations.
- The provider must take action to put in place an effective system to regularly assess and monitor the quality of the service. Although patients were consulted about some aspects of the service questions were not asked that enabled the provider to have an informed view of their opinion. Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In addition there were areas where the provider should make improvements:

- Although complaints were investigated and related learning was document there was no evidence that improvements took place following learning.
- Patients told us it was difficult to access GP appointments with some patients stating they had to wait up to a month for an appointment. Access to appointments was also difficult for patients who were working. The availability of appointments was not monitored by the practice.
- The arrangements for patients undergoing intimate examinations did not protect their privacy and dignity.
- Confidential information was disclosed at the reception desk and could be heard by people in the waiting area.

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. Staff understood their responsibilities to raise concerns, and reported incidents and near misses. When things went wrong reviews and investigations were carried out. However, these were only reviewed and communicated to all staff once a year. Out of date medication and equipment was found at the practice and there was no system in place to ensure that all of the medical equipment used by GPs was within its expiry date. There was no record kept of the amount of medicines stored in fridges, and although the serial numbers of blank prescriptions were recorded when they were received by the practice, no further checks were carried out, including when they were taken out on home visits.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity to consent and the promotion of good health. Staff had mostly received training appropriate to their roles. Staff appraisals and personal development plans were up to date. Multidisciplinary working was evidenced.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Data showed patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However the practice had a below average score for receptionists being helpful. We observed breaches of confidentiality at the reception desk. The privacy of patients having intimate examinations was not always respected and chaperone arrangements were not consistent.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the patient participation group (PPG) had carried out a patient survey this did not focus on the needs of their local population, or ask questions about how the service could be improved. Patients told us it was difficult to access an on the day appointment with some telling us they had to wait up to a month to see a GP. The appointment system was not monitored so the

Summary of findings

practice was not aware of the difficulties faced by patients. Complaints were investigated and there was a record of training being provided as a result of complaints made. However the records indicated that learning had not resulted from the training provided.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services . The practice had a statement of purpose but this was a short hand written document. Staff were not aware of its existence and we saw no evidence of the practice having a set of values. There was a leadership structure in place and staff told us they felt well supported. GPs told us they had no structured meetings but informal staff meetings were held. The practice had a PPG who carried out surveys. We saw no evidence that the views of the PPG were representative of the patient population and their focus was on changing the way patients accessed the practice, not improvements that may be needed in the practice.

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 requires improvement for the care of older people. Care and treatment did reflect current advice, and care plans were in place to avoid unplanned hospital admissions. Where needed longer appointments or home visits were arranged. We observed breaches of confidentiality during our inspection. Although reception staff spoke to patients in this population group respectfully and in a friendly manner, they also disclosed personal information in front of several other patients and visitors to the practice. Patients were encouraged to use an on-line system to order prescriptions and the patient participation group (PPG) wanted to encourage on-line appointment booking in the future, with less telephone access available. People in this population group had not been specifically consulted and it was not known what percentage of patients had Internet access.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. There was a process in place for patients to have an annual review of their condition and a GP reviewed and re-authorised their medicines every year. Patients expressed concerns about the availability of appointments. We saw that the PPG encouraged patients to use an on-line system to order prescriptions and they hoped to put in place on-line appointment booking. It was not known if this would be accessible to patients in this population group.

Families, children and young people

Requires improvement

The practice is rated as requiring improvement for the population group of families, children and young people. Patients with young children told us they were always able to access an on the day appointment where they had concerns about the health of their child. However, appointments outside school hours were very difficult to access. Midwives and health visitors attended the practice. There was a system in place to identify where children had not attended for routine childhood immunisations. The records of some children were not kept securely and were accessible by people not directly employed by the practice.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the working-age people (including those recently retired and students). The services

Summary of findings

available did not reflect the needs of this population group. On the day appointments were given on a first come first served basis, so patients who were unable to telephone the practice at 8am were not able to access these appointments. The practice was open until 6pm. Patients who worked or were at college found it difficult to access an appointment at a time convenient to them.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients with learning disabilities, but said they did not have any patients who were homeless or travellers. The practice had carried out annual health checks for people with learning disabilities. There were no arrangements in place to consult with this population group about changes that may be required at the practice. There was an ethos of encouraging patients to manage their own healthcare needs, but the self-care of vulnerable people had not been specifically considered.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). Counselling, including bereavement counselling, was offered to some patients at a time they needed it. However, patients reported that the arrangement was not consistent and one had had to bring their needs to the attention of the practice. The practice was trying to arrange for community psychiatric nurses to be involved with the practice. There were no arrangements in place to help patients manage their appointments, for example reminders near to their appointment time. Patients told us it was not unusual for them to have to wait longer than a week to access a GP.

Summary of findings

What people who use the service say

We spoke with eleven patients on the day of our inspection. We also spoke with three members of the patient participation group (PPG) by telephone and reviewed 27 CQC comments cards that had been completed by patients.

Of the eleven patients we spoke with three had booked their appointment on the day of our inspection. One told us they had managed to get an appointment but had to wait for 20 minutes before they managed to get through to a receptionist. Of the other eight patients one said they had had to wait a few days, three had waited a week, two had waited two weeks, one had waited three weeks and another patient said they had had to wait a month to access an appointment. Some patients said they struggled to get through to the practice on the telephone. However, one said the new system where a local telephone number was used was better because there was less cost involved.

The majority of patients spoke positively about the consultations they had with GPs and nurses. They said they were involved in decisions about their care and treatment and staff explained things to them in a way they understood. Some told us they had been referred to other services and given enough information about the service when this happened. Most patients reported that their conversations with reception staff could be overheard by other patients and visitors to the practice.

Of the 27 CQC comments cards we reviewed, 11 of them made reference to the long length of time between requesting and appointment and seeing a GP. One patient said that having been given an appointment they were unable to get through on the telephone when it was no longer needed. Another said the quality of the booking system had declined. However, patients with children in particular told us they were always given an appointment on the day they requested one. Most of the comments cards contained positive comments about the GPs and nurses, who were said to fully consider the needs of patients and treat patients respectfully and in a dignified way.

The PPG members we spoke with told us they felt valued by the practice and were consulted before any changes were made. They said they carried out patient surveys. Their opinion was that the problem regarding the accessibility of appointments was the number of patients who did not attend their pre-booked appointment.

Areas for improvement

Action the service MUST take to improve

- The provider must ensure there is an effective system to ensure an appropriate standard of cleanliness and hygiene were maintained throughout the practice was not in place. The provider is failing to meet Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must ensure there is an effective system to record what medicines are held at the practice and manage the disposal of medicines returned by patients. Blanks prescriptions must be kept in a secure manner. The provider is failing to meet Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations.
- The provider must take action to put in place an effective system to regularly assess and monitor the quality of the service. Although patients were consulted about some aspects of the service questions were not asked that enabled the provider to have an informed view of their opinion. The provider is failing to meet Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Action the service SHOULD take to improve

- Although complaints were investigated and related learning was document there was no evidence that improvements took place following learning.
- Patients told us it was difficult to access GP appointments with some patients stating they had to

wait up to a month for an appointment. Access to appointments was also difficult for patients who were working. The availability of appointments was not monitored by the practice.
- Not all staff had been trained in safeguarding vulnerable adults.
- The arrangements for patients undergoing intimate examinations meant that their privacy and dignity was not always maintained.
- Confidential information was disclosed at the reception desk and could be heard by people in the waiting area.

Dr R Anderson and Dr M Ahmed

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP, a specialist advisor and an expert by experience. An expert by experience is someone that has used health and social care service.

Background to Dr R Anderson and Dr M Ahmed

Dr R Anderson and Dr M Ahmed deliver primary care under a General Medical Services contract between themselves and NHS England. At the time of our inspection 6047 were registered with the practice.

The practice had two GP partners, one male and one female, and a male salaried GP. There was a nurse practitioner and three practice nurses, who were all female. The practice was a training practice and regularly had medical students. Other clinics were held at the practice. This included a midwives' clinic and a phlebotomy service.

The practice was open between the hours of 8am and 6pm Monday to Friday, except Wednesday when it closed at 1pm. The practice was closed at the weekends. Consultations with GPs were available between 9.10am and 6pm. There were no early morning, later evening or weekend appointments available. Patients could access the out of hours service by calling NHS 111.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

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

Detailed findings

- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care

People experiencing poor mental health

Before our inspection 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 14 October 2014. During our visit we spoke with a range of staff including GPs, the nurse practitioner, nurses, the practice manager and reception staff, and we spoke with patients who used the service. We observed how people were being cared for.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. These included reported incidents, national patient safety alerts and comments and complaints received from patients. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that significant events were appropriately identified and reported.

GPs told us they completed incident forms and carried out significant event analysis as part of their on-going professional development. We saw the template that staff completed if they were involved in any significant events. The staff we spoke with confirmed they were aware of their responsibility to raise concerns.

Reception staff had the responsibility of checking NHS websites for national safety alerts. We saw that information was printed and circulated to the clinicians. Staff signed to say they had read the information, and we saw this evidence was kept by the practice manager.

We reviewed the safety records and incident reports for the previous year and saw these were consistently recorded. The action taken as a result of incidents was recorded and provided evidence of a safe track record over time. The most recent annual review of incidents took place 1 April 2014.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and we saw a record of those that occurred in the previous 12 months. We saw how learning from each significant event had been implemented and this was discussed by the practice once a year as part of a formal review meeting. We saw evidence that where appropriate additional training had been provided for staff to ensure improvements were made following significant events occurring.

We saw that when a staff member completed an incident form this was given to the practice manager to manage and monitor. The practice manager told us where necessary they discussed the incidents with the GPs and a decision was made about any changes to practice that would be beneficial. We saw an example of an investigation taking place that resulted in an issue on the computer system being identified. This was then rectified to avoid a recurrence of the incident. Significant events were discussed with staff during an annual meeting. The practice manager told us they would like to start to discuss them at the more regular practice meetings.

National patient safety alerts were disseminated by reception staff. Printed versions of the alerts were provided for all staff to read, and clinicians signed to say they had read them. The staff we spoke with were aware of the system and able to give us examples of recent alerts. There was information recorded relating to any changes made as a result of national safety alerts.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review the risks to children and vulnerable adults. One of the GPs was the lead for safeguarding at the practice. We saw that the GPs had received training in safeguarding adults and children up to Level 3. The practice manager told us all staff had been trained to at least Level one in both adult and child safeguarding, and they thought the practice nurses had been trained to Level 3. We looked at the training record for all staff. These showed that GPs had been trained in safeguarding to the appropriate level, but not all other staff had been trained in safeguarding vulnerable adults. Following our inspection the practice manager provided us with certificates to evidence that only the deputy practice manager had not been trained in safeguarding vulnerable adults at the time of the inspection. This training was completed immediately following the inspection.

The practice manager met with health visitors every six weeks. Safeguarding issues were raised during these meetings and relevant information was shared with the GPs. The GPs and nurses kept a record of vulnerable adults and children who did not attend their pre-booked appointments. The practice manager told us they checked these and would raise concerns if they arose.

When children registered at the practice information about their parents, carers and school was recorded. If reports were received from other agencies these were scanned and kept with patients' notes. Records of attendances at the accident and emergency department, or where

immunisation appointments were not kept, were also included in the notes. However, there was no formal monitoring of this information and how to help identify safeguarding issues.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults registered at the practice.

There were notices and flow-charts in all the GP and nurses' rooms. This gave information about the process to follow if any safeguarding concerns were identified. Information about how to make a formal safeguarding referral and who to contact at the local authority for further advice was also provided.

There was a notice in the reception area informing patients they could request a chaperone during their appointments. The GPs and practice manager told us that it was usually the nurses that acted as chaperones. The reception staff we spoke with told us they also acted as chaperones. They said they had not received any formal training but one staff member said the practice manager had told them what to do. Their accounts of their role and responsibility whilst chaperoning varied. A privacy curtain was only available in one GP consultation room and chaperones had been instructed to stand both inside and outside the curtain. Staff also gave different accounts of the records kept following a chaperone being used. One staff member told us they were asked to record details of the event and another told us the GP always updated the records.

We saw that patient records were kept in a locked store room. However, we saw the records of some children were kept in an unlocked cupboard in a GPs room that was kept locked when unoccupied. The cleaner, who was not employed directly by the practice, had access to all these areas after all the staff had left the premises. We saw they had signed a confidentiality agreement.

Medicines Management

We checked the medicines stored at the practice. Medicines to be used in an emergency were available in all clinical rooms. We saw that these were managed by the nurse practitioner, who had a list of when medicines reached their expiry date. The nurse practitioner checked the availability of medicines in each clinical room every six months, and clinicians were responsible for carrying out their own informal checks in-between. A record of the check was kept for all rooms except the nurse practitioner's, who stated she personally checked her supply regularly.

Some medicines, including vaccinations, were kept in a fridge. There were two fridges at the practice where medicines were kept, one in the treatment room and one in the staff kitchen. The nurses recorded the temperature of the fridges on a daily basis and were aware of the action to take if the temperature was outside the required range. There were written procedures to follow if the temperature fluctuated and we saw evidence that a new fridge had been purchased during the month prior to our inspection after a fault was identified. The nurse practitioner told us that they rotated and monitored the stock to ensure the medicines kept in the fridges were in-date.

The unlocked fridge in the staff kitchen contained some medicine that had an expiry date of July 2013. Staff said they thought this had been brought in by a patient for disposal. The nurse practitioner told us they would check the type of medicine and dispose of it appropriately or ask the pharmacist to collect it.

We asked about checks of medicines kept in the fridges to make sure all medicines could be accounted for. The deputy manager told us they kept a record of medicine serial numbers for costing purposes. However, they did not keep information about how much of a particular medicine was held at the practice.

One of the GPs rooms contained several out of date items. Items that had been prescribed to patients, including medicines, were found in one drawer. These had expiry dates between June 2005 and October 2013. Single use instruments with an expiry date of February 2011 were in a cupboard alongside syringes with an expiry date of June 2009. A tube of lubricating jelly with an expiry date of February 2014 was on the counter-top in the room.

The practice manager told us that each GP was responsible for their own room and for making sure the equipment they used was in date. They told us no additional checks were carried out.

We asked about the checks in place to ensure the security of blank prescriptions. We were told that the numbers of the prescriptions were recorded when they were delivered

but no further checks were carried out. When blank prescriptions were taken on home visits their numbers were not recorded and there were no checks in place to ensure these prescriptions had been securely managed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. We saw evidence that GPs re-authorised repeat prescriptions at least every year and records were clear about when this reauthorisation was due. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

The GPs did not take emergency medicines on home visits as they were close to hospitals and pharmacies.

Cleanliness & Infection Control

During our inspection we looked in the GPs surgeries, nurses rooms, treatment rooms, the waiting areas, reception areas and patients' toilets. All appeared visibly clean.

We saw the infection control policy that was dated as being reviewed in October 2014. Several responsible people were named in the policy. The staff we spoke with were unsure about who was responsible for different aspects of infection prevention and control and their responsibilities were not recorded.

The cleaner was employed by a cleaning agency. We saw the cleaning specification that stated cleaning would be carried out between 6.30pm and 7.30am every Tuesday, Wednesday and Thursday. The practice manager told us the cleaner always attended when no other staff were on site, and they were able to clean at any time between the hours specified. There was a cleaning schedule in place but this did not cover all areas of the practice. Specific equipment, couches and work surfaces in the consultation and clinical rooms were not mentioned. The practice manager told us each clinician was responsible for their own surfaces, couches, and everything not on the cleaning schedule.

We spoke to the staff about their responsibilities in relation to the cleaning of the practice. One GP told us they used a wipe to clean the surfaces in their consultation room. However, the other GP we spoke with told us they thought the cleaners were responsible for all areas and they stated they did no cleaning in their room. The nurses also had different understandings of their responsibilities. One told us they used soapy water and a disposable cloth to clean their examination couch each night. Another told us they were unable to access the cleaner's store so they purchased their own cleaning equipment and cleaned their rooms each night. They said they took the cleaning equipment home each night and brought it back the next morning so it was not left on the premises.

One nurse had laundered the privacy curtains around their examination couch during the month of our inspection. They told us there was no protocol in place regarding the cleaning of curtains and screens, and the practice manager confirmed this. Another nurse had a folding vinyl screen. They told us they wiped this down themselves.

We saw that a nurse and the practice manager carried out an infection control audit in July 2014. Areas where improvements were required had been identified. We saw no formal action plan in place, although action required had been listed on an audit summary we were provided with as part of our inspection. It was not recorded who was responsible for carrying out the actions or when the improvements would be made by.

There was no protocol in place for the days the cleaner did not attend. However, we saw spillage kits were available in the treatment room. The deep cleaning of carpeted areas was not mentioned in the cleaning schedule and the practice manager told us they were not aware of the carpets in the GP consultation rooms ever being cleaned.

Disposable gloves were available in all consultation and treatment areas. However, we saw boxes of examination gloves that had an expiry date of earlier in 2014. The clinical waste bin in one GP consultation room was overflowing so the lid did not close. The practice manager said the clinical waste bins had been collected the day prior to our inspection but this one must have been missed.

The practice manager told us Legionella testing had not been carried out because a plumber had told them it was not required.

The staff we spoke with confirmed they had received infection control training, and this included instructions on specimen handling and hand washing. The training records we looked at did not contain evidence of infection control training being carried out for all staff, and there was no record of one of the nurses attending any training.

Requires improvement

Are services safe?

The infection control policy was very short and did not contain enough information to guide staff about their responsibilities or what standards were expected within the practice. However, it did state that a named GP and nurse were responsible for the provision of personal cleaning supplies for within clinical areas, and the practice manager was responsible for the provision of personal cleaning supplies within non-clinical areas. A named GP and nurse were responsible to ensure all items were within their expiry date. There was no mention of the responsibilities of the cleaners. The policy also stated that cleaning checks were carried out regularly, but did not state who was responsible. The practice manager told us there were no formal checks to confirm cleaning was carried out to the appropriate standard.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example weighing scales and the blood pressure monitor. Fire extinguishers were also checked annually.

All computers had a panic button. Staff told us this would be used if they needed any help, if there was a fire, and if for example a patient collapsed. If any panic button was used an alert was shown on every computer in the practice so help could be provided.

Staffing & Recruitment

The deputy manager managed the staff rotas. They told us they had more staff on duty when they anticipated they would be busy. This included times such as the day following a bank holiday. We were told that one day a week was busier than others due to the clinics that were being run. We saw evidence that extra staff were available at this time to cope with the heavier workload in the reception area.

The records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment commencing. We saw that proof of identity was seen for staff, their references and qualifications were checked and a Disclosure and Barring Service (DBS) check was carried out appropriately. However, we saw the training record for a nurse who had started work earlier in 2014. They had been asked for information about their training in April 2014 and it had not been supplied by the date of our inspection. A check was carried out to ensure clinicians were registered with the appropriate professional body. The practice manager told us they monitored registration with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) informally. All GPs had up to day medical indemnity insurance. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice did not regularly use locum doctors. The GPs covered each other for unplanned absences. For planned annual leave a locum agency was used. They tried to use a locum that was already known to the practice. The nurse practitioner did not take annual leave at the same time as the GPs. The practice manager and deputy practice manager also did not take annual leave at the same time as each other.

Monitoring Safety & Responding to Risk

The practice had a system in place to manage and monitor risks to patients, staff and visitors to the practice. We saw that the practice manager had a regular walk around of different areas of the practice to assess any risk. The last check had been carried out 10 September 2014, when the outside of the building and hallway were checked. Prior to this the inside of the building was checked on 15 July 2014. We saw that where any repairs were deemed necessary these were promptly arranged.

Any identified risks were recorded and monitored. Staff told us they were aware to report any risks they identified. Staff also told us they were aware everyone was responsible for looking out for risks and hazards, and the practice manager kept them updated of any issues they needed to be aware of.

We saw evidence that checks on equipment and medication were carried out. However, some out of date medication and equipment had not been identified.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was

Requires improvement

Are services safe?

available including access to oxygen and an automated external defibrillator (AED). All the staff we asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in all treatment rooms. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. The staff training records we saw contained no evidence of staff ever having training in fire safety. Following our inspection the practice manager told us staff had been trained on 8 January 2013 but evidence had been kept in a separate folder. They told us that updated training had been booked for February 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The patients we spoke with told us they felt they usually received care appropriate to their needs. Most told us they were involved in discussions about their care and treatment and where choices were available they could make their own decisions with support from the GP.

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

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Care plans had been introduced and implemented for just over two per cent of the population. These were with a view to avoiding unplanned hospital admissions in high risk patients. The care of these patients was co-ordinated with other providers in the area, and GPs attended multi-disciplinary team meetings where required to manage the needs of these patients.

The GPs told us they led in specialist clinical areas such as orthopaedics, women's health and minor surgery. The nurses had a joint responsibility for managing patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). Patients were included on the appropriate registers for patients with long term conditions. We saw that the nurse arranged annual reviews for all patients with long term conditions. Where a patient did not attend an annual review the nurses telephoned the patient and visited them at home where necessary.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. The practice manager and their deputy were responsible for updating the registers of people with newly diagnosed conditions, as well as information about their smoking and alcohol consumption status.

GPs told us that on the rare occasions they used a locum GP that wasn't known to them they carried out checks on their records and consultations.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We saw extensive evidence that GPs were aware of audit procedures. Action plans were put in place during audit cycles and these were kept as evidence in individual GPs' appraisal files. Examples of audits included anti-biotic prescribing, where prescribing was reduced in line with Health Protection Agency guidance, and chlamydia audits.

The GPs showed us they had a good system in place for accessing Electrocardiogram (ECG) results. The ECG monitoring machine sent an electronic report via the telephone line to the hospital. A report from an expert was faxed back to the practice within 20 minutes.

Doctors undertook minor surgical procedures in line with their registration and NICE guidance. Audits were undertaken on the results of minor surgery.

Each GP had an email in-box where patients' test results were sent. If a GP was off duty test results could be accessed by another GP via a global in-box. Where a test result was abnormal or further tests were required the GP informed a receptionist who would telephone the patient and make an appointment for them to see a GP. We saw there had been a recent drive to validate patients' telephone numbers to make sure patients could be contacted in a timely manner when required.

Nurses managed the reviews for patients with long term conditions. There was a system in place to ensure patients were reviewed at regular intervals. There was also a system in place to ensure a GP reviewed and authorised the medicines of patients who had regular medicines on a repeat prescription.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling,

Good

Are services effective?

(for example, treatment is effective)

child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager and relevant staff were informed.

Effective staffing

The practice had three GPs, a nurse practitioner, three practice nurses and reception and administration staff. There was a system to ensure staff did not book annual leave at the same time leaving the practice under-staffed. It had been identified that the practice was busier one day a week and extra staff were included on the rota for this day.

The GPs and nurses were up to date with their continuing professional development (CPD). We reviewed staff training records. Most mandatory training was up to date and all staff had received training in basic life support. Training was either organised by the practice or accessed on-line.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. The staff we spoke with confirmed they had an annual appraisal meeting with their manager with informal meetings in-between their formal appraisal. There was an induction programme in place for staff new to the practice to follow.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Test results were received, usually electronically, and actioned by the relevant GP. Reports were also reviewed following a patient attending the accident and emergency department or walk in centre.

We saw that where a patient used the out of hours service the practice was contacted the following working day. We saw evidence of liaison with the out of hours service when a patient was nearing the end of their life, or a new 'do not attempt cardio pulmonary resuscitation' order had been put in place for a patient. This was to ensure the continuity of the most appropriate care for a patient.

The practice was notified when a patient was discharged from hospital. GPs told us they liaised with other services such as district nurses, palliative care teams, hospices and Macmillan nurses to ensure continuity of care was provided. They attended regular multi-disciplinary meetings for patients with complex needs.

GPs and nurses liaised with the managers of sheltered accommodation in the area. This was to ensure continuity of care and also identify patients who may need assistance but had not contacted the practice.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Hospital letters and discharge documents were reviewed by a GP in a timely manner.

Although the practice did not hold formal meetings, they met regularly on an informal basis. Staff confirmed that they were kept up to date with issues within the practice, and some staff described their responsibilities in relation to cascading relevant information to staff.

The patient participation group (PPG) produced a newsletter for patients. This provided some information about the practice, along with information about events being held in the area.

Consent to care and treatment

The GPs and nurses we spoke with understood their responsibilities around consent and decision making for patients. They were able to describe when written, verbal or implied consent was appropriate. They also had a clear understanding of the Gillick competencies, used to help clinicians identify children under the age of 16 who had the legal capacity to consent to medical examination or treatment.

We saw that the nurses had received training on the Mental Capacity Act 2005. They understood their responsibilities for ensuring patients understood their care and treatment, and were aware of the procedure to follow if a patient did not have the capacity to consent. We saw the proforma used by clinicians to assess if a patient had the capacity to consent. Nurses told us that if they knew a patient was confused they would make them a longer appointment and be sure to explain things to them in a way they understood.

The practice was a training practice and there were often two medical students present during consultations. Patients were informed of this when they entered the

Good

Are services effective?

(for example, treatment is effective)

practice and they were told they were able to ask the medical students to leave the room. Where the patient agreed to the medical students being present they signed a form agreeing their consent.

Health Promotion & Prevention

All new patients were offered a new patient health check with a nurse. This included discussions about their family and medical history, current issues and medicines and their lifestyle. Lifestyle advice was given if required, and an appointment with a GP could be made if further investigations were necessary.

The practice looked at all unplanned hospital admissions with a view to reducing them. Care plans were in place for the most at-risk patients. GPs monitored hospital admissions and considered ways of managing a patient's condition at home. Where patients had a long term condition these were reviewed at least annually and any changes to a patient's condition could be managed.

Flu vaccinations were provided to patients as required. The GPs and nurses were proactive in providing immunisations to patients who qualified for a flu vaccination if they attended the practice for any other matter. Shingles immunisations were also given to patients in the appropriate age group. The practice monitored the take-up rate of these vaccinations and said that most patients attended for their vaccination without being reminded.

The practice offered a full range of immunisations for children and travel vaccines in line with current national guidance.

The waiting area contained information about health promotion. The PPG were proactive in encouraging patients to look after their own health. We saw they had arranged talks and courses for interested patients. These included a HeartStart course to inform patients how to act if someone has a sudden cardiac arrest.

Requires improvement

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the results of the most recent national GP survey. This showed that 87% of patients seeing a GP and 91% of patients seeing a nurse said they were treated with care and concern. Both these figures were higher than the clinical commissioning group (CCG) average for the area. The results for GPs and nurses being good at listening to patients were also above average for the area. However the practice scored below the CCG average for receptionists being helpful and the level of privacy when speaking to a receptionist at the practice.

We observed the reception area during our inspection. Patients were huddled next to the reception desk so there was no privacy when speaking with a receptionist. A receptionist asked one patient what they were attending for, and they gave full details that could be overheard by patients in the waiting area. Another patient was greeted in a friendly manner and asked if they were attending for their blood test. They were attending for another matter, and this conversation again was heard by patients in the waiting area. We saw a patient being greeted by name at the reception desk. They were asked about their fasting prior to the test that was to be carried out. While in the waiting area we heard a staff member telephone a patient and call them by their name, which was an unusual name. A discussion took place about a forthcoming Electrocardiogram (ECG) appointment. Staff told us they had been trained in patient privacy and there had not been any issues maintaining privacy and confidentiality on the reception desk. Our observations showed that confidential information was discussed within hearing distance of other patients and visitors to the practice. The majority of the patients we spoke with told us they thought their conversations with a receptionist could be overheard. However, they said they were aware there was a private room available if they wanted to speak to a staff member in confidence.

The majority of the patients we spoke with told us they were treated with dignity and respect by staff at the practice. Only one of the patients we spoke with told us they had been offered a chaperone if they required an intimate examination, but others told us they were aware they could ask for one. Most patients told us they were given enough time during their appointments, and that GPs and nurses explained things to them in a way they understood.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains around examination couches to maintain the privacy and dignity of patients during examinations were only available in one of the three GP consultation rooms. One male GP, who had a large consultation room but no privacy curtain, told us they always left the room while the patient undressed prior to an intimate examination and the chaperone informed them when they could enter again. Other staff confirmed this happened. These arrangements meant patients were unable to undress in private. Also, the arrangement where a male GP was required to wait outside their room in a corridor used by other patients meant other patients and visitors to the practice were aware an intimate examination was taking place.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 78% of practice respondents said the GP involved them in care decisions, and 84% of patients said the nurses did the same. Both these figures were above the CCG average for the area.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they usually 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.

Staff told us it was very rare for a patient not to speak English as their first language. The practice had access to a telephone translation service, but the practice manager told us they had never needed to use it. One of the GPs spoke an Eastern European language and the nurse practitioner was able to use sign language.

Requires improvement

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Four of the twelve patients we spoke with told us they had been offered emotional support by the practice. This included counselling, such as bereavement counselling. Patients indicated they were usually treated in a caring way by staff at the practice. The CQC comments cards we reviewed also indicated patients received the necessary emotional support.

The national survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example 87% of patients said the GP treated them with care and concern and 91% of patients said the same of the nurses. Both these figures were above the CCG average for the area. and rated it well in this area.

The reception area contained information about how patients could access emotional support such as counselling. Information about how carers could access support was also given. A television screen in the waiting area also provided patients with this information.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw that patients who were housebound were easily identifiable. The nurse practitioner told us these patients received home visits when they were due a review of their long term conditions. They were also visited during the winter flu vaccination programme. Appointments at the practice were usually for 10 minutes. The nurse practitioner told us that where they felt a longer appointment would be beneficial, for example if a patient had a learning disability, this would be arranged.

The GPs attended palliative care meetings regularly to ensure the needs of their patients requiring palliative care were met. A health visitor attended the practice every six weeks. Integrated neighbourhood team meetings also took place eight times a year. These meetings meant the practice could discuss ways of responding to the individual needs of patients. GPs told us that although mental health services could be difficult to access they were trying to involve community psychiatric nurses (CPNs) more with the practice to help meet the needs of patients with mental health issues.

The practice had an active patient participation group (PPG). We spoke with three members of the PPG individually. They spoke highly of the practice and the GPs, and the GPs referred to the PPG as a good bunch, saying they always took into consideration the views of the PPG before making any changes. The PPG were able to give us one example of a change made following feedback from the group; the broken information screen in the reception area had been replaced. The PPG carried out surveys to collect the opinion of patients. However, there were few questions that related to the satisfaction of patients. There was therefore no data available about how well the practice was meeting the needs of the patients.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and they did not have concerns about their level of responsiveness.

Tackle inequity and promote equality

Staff told us there was little diversity within their patient population. They were aware of how to access translation services but said they had never had to do this. They told us they were not aware of any homeless patients or travellers, and did not have patients where they had to be mindful of cultural differences. However, the staff said if these patient groups did register with the practice their needs would be met and additional training would be provided where required. Staff had received training in equality and diversity. In addition one staff member volunteered for a charity to help the homeless in the Salford area, and so had extra awareness of issues affecting some patient groups.

The practice was aware of patients with a learning disability. They were offered longer appointments and their carers sometimes attended the practice with them. A record was also kept of patients with caring responsibilities. Information was available in the reception area regarding support for carers and GPs were aware of local carers groups, referring patients where appropriate.

Large print leaflets, including information provided to new patients, were available in large print. There was a hearing loop in reception to assist patients who were hard of hearing. The nurse practitioner was also able to use sign language.

The premises and services met the needs of patients with disabilities. All consultation rooms were on the ground floor and there was space for wheelchairs.

Access to the service

We saw that GP appointments were available to pre-book four weeks in advance. Appointments with the nurses were available 11 to 12 weeks in advance. 'On the day' appointments were also available.

The practice was open from 8am until 6pm, Monday to Friday, except on a Wednesday when it closed at 1pm. Appointments with GPs started at 9.10am, and the website stated there was a GP available until 6pm every day except Wednesday when appointments finished at 11.30am. The GPs told us they opened until 6pm, so that patients who worked could access appointments. In an emergency patients could be seen after this time but the last routine appointment was at 5.50pm. The practice was closed at weekends. Patients could access an out of hours service when the practice was closed.

The GPs explained that in 2003 there were two GPs and 3000 patients. There were currently 6047 patients and three GPs. They told us that the nurse practitioner had worked alongside the GPs for over a year. They saw patients in the same way GPs did and the patients understood the nurse

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

practitioner's role and would specifically ask to see them. The GPs told us that if the nurse practitioner thought a patient needed to see a GP they would ask one to see the patient.

On-the-day emergency appointments were given to patients on a first come first served basis. When the on-the-day emergency appointments had been booked up patients who said they needed to be seen were spoken to on the telephone by a GP or the nurse practitioner who triaged their needs. The GPs told us that if there was an urgent need for the patient to be seen they were booked in to see a GP. However, they said the triage telephone system was really for patients who did not need a face to face appointment. Staff told us that if there were no available on- the-day appointments patients were asked to telephone after 3.30pm to see if any had become available.

We looked at the appointments available at the practice. The next available appointment to see a GP was in one week and the next nurse appointment was in three working days. We asked the practice for the number of GP appointments they had had available for the two weeks prior to our inspection. We saw that during the week prior to our inspection 343 appointments were available. These were not just for GP appointments. They included appointments with the nurse practitioner and telephone consultations. Guidance from the Department of Health states that analysis showed practices offering more than 70 GP appointments per 1000 patients per week were able to meet patient demand. This practice offered fewer GP appointments to their patients during this week. The other week's data they supplied was for a month prior to our inspection. The practice also provided us with data from a week one month prior to our inspection. During this week the number of appointments for GPs and the nurse practitioner, along with telephone consultations, was 418.

We spoke with 11 patients who were attending the practice for an appointment. Three of those had been able to make an on the day appointment, with one saying they telephoned for 20 minutes from when the practice opened so they could access an on- the-day appointment. The other patients had waited between one week and one month to access an appointment, with one patient saying they could only access an on- the-day appointment if they were available at 8am.

We reviewed 27 CQC patient comments cards. Eleven patients mentioned they had difficulty accessing appointments. Patients told us they had to wait up to two weeks to see a GP, with one patient saying they had been offered an appointment for their teenage grandson 16 working days after they requested it. However, most patients said if their children were ill they were seen on the day they asked for an appointment.

Patients told us they found it difficult to get through to the practice on the telephone. We saw that although patients had not been specifically asked about their experience of contacting the practice by telephone or the availability of appointments, patients had given their opinion during the 2014 PPG patient survey. Several patients expressed their dis-satisfaction. The practice manager told us there was no monitoring of the appointments system so they did not know how many patients were unable to access an appointment at the time they needed one.

The most recent national GP patient survey showed that 58% of patients said their experience of making an appointment was good. This was below the CCG average of 79%.

The practice had patient consultation rooms on the ground floor only. All rooms were accessible for patients with mobility difficulties. There were large waiting areas. There was a small car park at the practice and two spaces were available close to the front door for patients with mobility difficulties.

Staff at the practice told us they were not aware of any patients who did not speak English as their first language.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. This was managed by the practice manager. We saw a summary of the complaints that had been made to the practice in the 12 months prior to our inspection. These included verbal complaints made by patients. We saw that all complaints were acknowledged and then investigated.

Patients who made a complaint about a clinical matter were routinely offered an appointment with a GP. These meetings were held in private with only the GP and the patient making the complaint present. The GP told us they were happy to have these meetings and there had never been any concerns raised about there being no independent witnesses to record the meetings. The GP said they briefed the practice manager following the meeting so

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

they could respond formally to the patient. The practice manager told us they felt some group training to staff about how complaints should be handled would be beneficial to staff.

We saw that where learning needs were identified following a complaint being made these were recorded as being implemented. Sixteen complaints had been made in the 12 months prior to out inspection. Eight of these were said to have resulted in in-house training for reception staff on dealing with patients. Some of the complaints were regarding the attitude of reception staff. We saw the training records for staff. In house training had been provided to reception staff on dealing with patients on 20 March 2014. However, the practice was unable to evidence that staff had learned from complaints

The staff we spoke with told us they would ask patients to put complaints in writing to the practice manager. However, they said they would always pass on verbal complaints to the practice manager for them to deal with.

We saw there was a 'complaints procedure and suggestions' section on the practice leaflet. This did not give information about the complaints procedure but stated that constructive comments and complaints were valued. A leaflet from the CCG about how to make a complaint was available on the reception desk. Comments could be made via an on-line form on the practice's website. The website stated this form should not be used for official complaints, but no further information about how to make official complaints was provided.

There was a comments box in the reception area. Members of the PPG told us they reviewed these comments but a record of them, and any changes made as a result of comments, was not kept.

Most of the patients we spoke with told us they knew how they could make a complaint. One patient told us they did not know what the process was and would not feel comfortable complaining.

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. This was a series of hand written documents that were not always easy to read due to over-writing and alterations. Seven aims and objectives of the practice were recorded but these were generalised. Examples included that the practice aimed to provide a safe environment for the care of patients and staff, and they aimed to fulfil the requirement of health and safety for the patients and staff.

Staff we spoke with were unaware of the aims and objectives of the practice. They were not displayed and were not available on the website. No other practice visions or values were seen during our inspection.

All the GPs at the practice were under the age of 50 and planned to continue working for many years. For this reason there was no succession planning and no business plan was in place.

Governance Arrangements

We reviewed some of the policies that were in place at the practice. Some policies, such as the infection control policy, did not contain enough information to guide staff. The policies usually contained a date when they had been reviewed but no date was given for future reviews. There was no evidence that the policies had been fully embedded into the workings of the practice.

The GPs told us they did not have structured meetings, but there was sometimes an end of surgery catch up between the GPs and the nurses. They told us that informal practice meetings for all staff were held approximately every six to eight weeks. Staff told us these informal meetings were held approximately every month during their lunch break. The practice manager and deputy worked together so had good communication. Staff told us that they were informed of any changes within the practice or given any important information by the practice manager on an 'as and when' basis. They told us they felt well informed and were able to ask the practice manager questions at any time.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. The deputy manager was responsible for submitting information to the Clinical Commissioning Group (CCG) and the practice manager was responsible for claiming payments due to the practice.

Leadership, openness and transparency

We saw that there was a leadership structure in place. GPs took the lead for areas such as safeguarding, training, and minor surgery. The lead for some areas, such as infection control where several staff members were mentioned in the policy, were unclear. However, the staff we spoke with were able to describe their areas of responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us they had the opportunity to ask questions during staff meetings, and they could approach the practice manager, who had an open door policy, at any time. Staff had not heard of a whistleblowing policy but said they would tell the practice manager if they had concerns. Staff confirmed that regular meetings were held.

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

The practice had an active patient participation group (PPG). Members of the PPG told us they felt valued by the practice, were consulted prior to changes being made and were able to give feedback to the practice at any time. They told us they carried out a patient survey.

We saw the most recent patient survey the PPG had carried out during 2014. Patients were asked how satisfied they were with getting through to speak with someone on the telephone, their experience of seeing or speaking with a nurse of GP on the same or next day they made a request and their overall experience of making an appointment. There were more positive than negative responses and these were not reflective of the information given to us by patients on the day of our inspection or the CQC comments cards completed by patients as part of our inspection. Other questions related to patients' awareness of services offered, their confidence in contacting the practice on-line, their long-term conditions and how people could self-care and take responsibility for their own health.

Members of the PPG told us they knew patients were dissatisfied with the availability of appointments, and they were trying to find ways of managing this. They said they thought the lack of appointments was due to the number of patients who did failed to attend their appointments.

Are services well-led?

Requires improvement

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

The reasons behind patients not attending had not been explored. One patient stated on a CQC comments card they had been unable to get through on the telephone to cancel an appointment. Providing extra appointments for patients had not been mentioned. PPG members told us about possible solutions to the lack of appointments. These included encouraging patients to self-care, providing information about other groups in the area that could help, such as Age UK, and charging patients for their appointments if they failed to attend. We saw no evidence that these views were representative of the patient population.

The PPG had also discussed how to respond to concerns about difficulty getting through to the practice by telephone. They aimed to encourage patients to use the on-line repeat prescription ordering service. Their action plan also included reducing the number of telephone calls taken so that in the long-term patients would be encouraged to book their appointments on-line. At the time of our inspection appointments could not be booked on-line, and it was not anticipated that this service would start prior to mid-2015.

The effectiveness of the PPG, and whether or not their views were reflective of the whole patient population, was not monitored by the practice.

There was no formal way of gathering the views of staff members. However, all the staff we spoke with told us the practice manager was approachable and they were able to raise any concerns they had.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Nurses said that although they had opportunities for training and development this was often in their own time as it could not be fit in during their working hours. Reception staff told us they were informed when they needed to update their training. Some training was available on-line and some was provided by the practice during meetings.

We looked at a selection of staff files and saw that regular appraisals took place which included a personal development plan. The GPs appraised the practice manager, the deputy practice manager, and the nurses. The deputy practice manager had the responsibility for carrying out appraisals for other staff. The practice manager kept a training record for all staff but there was no record of when the training should be updated. We saw evidence that the GPs had an appraiser and their appraisals were up to date.

The practice was a GP training practice. Year 3 and 4 medical students attended the practice usually for two days each week. One of the GPs took responsibility for their training. They told us the students attended the practice in pairs and took consultations with the GP also in attendance. They said this was the preferred method of the university so that students could learn from each other. Feedback from the university was positive.

Significant event reviews were shared with staff once a year. Learning from complaints that had been made was shared with staff on an ad-hoc basis.

This section is primarily information for the provider

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **There was no system in place to ensure appropriate standards of cleanliness or hygiene were maintained throughout the practice.** **Regulation 12 (1) (2) (a).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **There was no effective system to record what medicines were held at the practice or dispose of medicines returned by patients.** **Regulation 13.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **An effective system to regularly assess and monitor the quality or the service was not in place. Although patients were consulted about some aspects of the service questions were not asked that enabled the provider to have an informed view of their opinion.** **Regulation 10 (1) (a) (2) (b) (i)**