

Dr Abdul Raouf Ismail Al Sayed

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Brimpton House Surgery on 31 March 2015. Overall the practice is rated as good.

Specifically, we found the practice requires improvement for providing safe services and good for providing effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long-term conditions, families and young children, working age people, people whose circumstances made them vulnerable and those suffering from poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.

- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found the appointment system easy to use with urgent appointments available the same day.
- The practice were aware of their performance data and knew where improvements were required and were taking steps to achieve them

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

Importantly the provider must;

Summary of findings

- Ensure recruitment processes are more robust including a consistent approach to taking references, undertaking disclosure and barring service checks, checking qualifications and the completion of induction programmes for new staff.

Importantly the provider should;

- Ensure governance issues and safety incidents and complaints, discussed at meetings are clearly documented to ensure actions required are not missed and that there are clear lines of accountability for action.

- Establish a written policy for the review of medications including the monitoring of those medications that need regular blood or other tests.
- Undertake a legionella risk assessment and implement risk prevention measures if required.
- Complete an analysis of the patient survey undertaken in November 2014 and produce an action plan and timescales for improvements
- Establish a system to obtain feedback from staff about the services provided at the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated at team meetings and informally. There was no system to document that learning had taken place and areas for improvement actioned. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe. A formal review system was not in place to review patients' prescription requests. Staff had been trained to manage emergencies and medicines and equipment were readily available and fit for use. Infection control procedures were robust. A legionella risk assessment had not taken place. Recruitment procedures and induction processes were inconsistently applied.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed that most patient outcomes were average for the locality. The practice was aware of where improvements were required and were working towards them. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Practice staff were aware of consent issues and how they affected patients with limited mental capacity. Staff had received training appropriate to their roles and training needs were reviewed annually and planned. An appraisal process was in place that included the opportunity for staff to develop. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients were satisfied they were being treated with compassion, dignity and respect. Patients were involved in decisions about their care and treatment. Information to help patients be aware of the services available was easy to understand. Staff maintained patient confidentiality and sought verbal or written consent when appropriate. Support was available at the practice and externally for those suffering bereavement or who had caring responsibilities.

Good



Are services responsive to people's needs?

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

Good



Summary of findings

that met their needs. Patients said they found it easy to make an appointment with a named GP with urgent appointments available the same day. The practice was pro-active in improving the appointment system. The practice sought views about the services provided from their patient participation group. Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised. Learning from complaints was being shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had clear aims and objectives and all staff worked towards them as part of a team. Staff were clear about the vision and their responsibilities and felt supported by management. Regular governance and team meetings took place, but these were not minuted. The practice had a range of policies and procedures to govern activity and support staff. There were systems in place to monitor and improve quality and identify risk. The practice undertook a patient survey to seek the views of patients but had not completed an analysis to identify areas for improvement. The NHS Friends and Family test reflected that the majority of patients would recommend the practice. There was no formal system in place to seek the views of staff about the services provided.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The provider is rated as good for effective, caring, responsive and well-led overall and this includes for this population group. The provider was rated as requires improvement for safety. 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 older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. Patients with palliative care needs or who were frail were monitored to reduce the risk of hospital admissions and care planned that met their needs. Regular meetings took place with other healthcare professionals to identify care requirements but these were not minuted. Patients suffering from dementia received annual health checks. Each patient over 75 had a named GP and could see a GP of their choice whenever available. Home visits and telephone consultations were available for those housebound or too ill to attend the practice. Flu and shingles vaccination programmes were readily available to help keep patients healthy.

Good



People with long term conditions

The provider is rated as good for effective, caring, responsive and well-led overall and this includes for this population group. The provider was rated as requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group. Patients with such conditions were recorded on a register and their healthcare needs reviewed annually or sooner if required. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. For those patients with complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients were signposted to external organisations that provided support. Patients with palliative care needs were regularly monitored and relatives and carers involved in the planning of their treatment. The practice had plans in place to improve the monitoring of patients with diabetes.

Good



Families, children and young people

The provider is rated as good for effective, caring, responsive and well-led overall and this includes for this population group. The provider was rated as requires improvement for safety. The concerns

Good



Summary of findings

which led to these ratings apply to everyone using the practice, including this population group. There were systems in place to identify children vulnerable to abuse. Staff had received safeguarding training. Immunisation rates were average across the area for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Partnership working with community midwives and health visitors took place regularly.

Working age people (including those recently retired and students)

Good



The provider is rated as good for effective, caring, responsive and well-led overall and this includes for this population group. The provider was rated as requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group. The needs of the working age population, those recently retired and students had been identified. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. A late evening surgery was available for those patients who had work commitments. A full range of health promotion and screening was available for patients.

People whose circumstances may make them vulnerable

Good



The provider is rated as good for effective, caring, responsive and well-led overall and this includes for this population group. The provider was rated as requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group. Health checks were carried out annually or sooner if necessary. Longer appointments were available for consultations if required. Patients were signposted to external organisations that provided support. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding documentation of safeguarding concerns and how to contact relevant agencies in normal working hours or out of hours.

People experiencing poor mental health (including people with dementia)

Good



The provider is rated as good for effective, caring, responsive and well-led overall and this includes for this population group. The provider was rated as requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group. Patients were identified and their health monitored. People experiencing poor mental health had received an annual physical health check. A mental health counselling service attended the practice each week for patients to

Summary of findings

access. Patients at risk of developing dementia were offered health checks to enable early identification of the condition. The practice signposted patients experiencing poor mental health to various support groups and voluntary organisations.

Summary of findings

What people who use the service say

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 38 cards that had been left for us and reviewed the comments made.

All of the comment cards we viewed contained complimentary comments about the GP, nurse, reception staff and the services provided. Patients commented that the care provided by the GP and nursing staff was of a high standard and met their needs. They found the appointment system easy to use and could obtain one at a time that suited them. They said the clinical and non-clinical staff were kind, caring, supportive and treated them with dignity and respect. Patients commented that children were treated kindly and that emergency appointments were available when needed. They found the practice clean and hygienic. There was only one negative comment received about the practice.

We spoke with two patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. They said they were treated with dignity and respect and that clinical staff gave them the time they needed at consultations. We were told that the appointment system was easy to use and that they could get through to the surgery on the phone.

The NHS Friends and Family test had recently been carried out by the practice. This reflected that patients were either extremely likely or likely to recommend the practice.

Areas for improvement

Action the service **MUST** take to improve

Ensure recruitment processes are more robust including a consistent approach to taking references, undertaking disclosure and barring service checks, checking qualifications and the completion of induction programmes for new staff.

Action the service **SHOULD** take to improve

- Ensure governance issues and safety incidents and complaints, discussed at meetings are clearly documented to ensure actions required are not missed and that there are clear lines of accountability for action.

- Establish a written policy for the review of medications including the monitoring of those medications that need regular blood or other tests.
- Undertake a legionella risk assessment and implement risk prevention measures if required.
- Complete an analysis of the patient survey undertaken in November 2014 and produce an action plan and timescales for improvements
- Establish a system to obtain feedback from staff about the services provided at the practice.

Dr Abdul Raouf Ismail Al Sayed

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.

Background to Dr Abdul Raouf Ismail Al Sayed

Brimpton House Surgery is situated in Kelvedon, Essex. The practice is one of 48 GP practices in the Mid Essex Clinical Commissioning (CCG) area. The practice has a general medical services (GMS) contract with the NHS. There are approximately 3000 patients registered there.

The practice has one GP working at the practice with the occasional use of a locum GP. There is one practice nurse supported by two healthcare assistants, one of whom is also a receptionist. The clinical staff are supported by a practice manager and a deputy practice manager and a number of receptionists and administration staff.

The practice is open for appointments 8.30am to 5.30pm on weekdays and one late evening takes place each Wednesday until 8pm. The practice is closed at weekends.

The practice has opted out of providing 'out of hours' services to their own patients. If emergency medical help is required patients call the main practice telephone number and they are directed to an out of hour's service. Otherwise non-urgent medical advice is available using the 111 system.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

Detailed findings

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)

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 then carried out an announced visit on 31 March 2015. During our visit we spoke with a range of staff including one GP, two nurses, the practice manager and reception and administration staff. We also spoke with two patients who used the service. We reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice and we viewed them afterwards.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included responding to national patient safety and medicines alerts, the analysis of significant events and the investigation of complaints. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses and this was encouraged at the practice.

Alerts from the National Patient Safety Agency and the Medicines and Healthcare Products Regulatory Agency were received at the practice by the practice manager and sent direct to the GP for a clinical review. This often meant identifying those patients affected by the alert and reviewing their treatment or medicines. An audit trail was maintained with the GP noting any action to take, followed up by an entry in the patient record.

We reviewed significant event records and complaints and could see that they had been investigated appropriately to identify safety concerns. We found that safety issues were discussed at management level and team meetings, improvements identified and action taken if necessary. We found that minutes of meetings were not being recorded and we were not assured that all staff had the opportunity of learning from these incidents. It was evident however that there was a positive reporting culture. Staff made use of a note book to record any ideas or suggestions including potential safety issues. This book was monitored by the practice manager and discussed informally.

Learning and improvement from safety incidents

The practice had a system in place for identifying, recording and analysing safety incidents. Staff, including receptionists, administrators and nursing staff, knew how to report a concern and there were forms available for that purpose. Staff spoken with told us that they were encouraged to raise issues if they identified them and felt that the GP and practice manager were supportive.

Significant events and complaints that had taken place were recorded, investigated, analysed and learning identified. Where necessary appropriate explanations and apologies were offered to patients. We looked at the records of two significant events that had taken place in the last 12 months and found that they had been dealt with

effectively and learning identified. The significant events we viewed were generally in relation to secondary care but the practice had fed back to those concerned, the learning identified so that they were aware of the issues and could implement improvements to their systems and processes.

We were told by the practice manager and staff we interviewed that learning from safety incidents was cascaded to staff at team meetings held every three months but this was not recorded. Staff spoken with were aware of the learning from them. If actions had been identified, such as a new procedure or a change of system, it was not clear that they had taken place and completed in a timely manner, due to the absence of minutes and an action plan. The absence of minutes also meant that staff unable to attend team meetings may not have been aware of the learning from the incidents.

Reliable safety systems and processes including safeguarding

The practice had a nominated lead for safeguarding and this was the GP supported by the practice nurse. Both had received appropriate training to enable them to carry out the role. All clinical staff had received safeguarding training and this was a mixture of face to face and on-line training.

The practice had systems to manage and review risks to vulnerable children, young people and adults, including highlighting vulnerable patients on the practice's electronic records. At the time of our inspection there were no children on the 'at risk' register at the practice.

Staff we spoke with displayed knowledge of the different signs of abuse in older people, vulnerable adults and children. They were aware of the procedures to follow and who to inform at the practice if they identified a concern. Information was available that was displayed in the practice about external agencies they could contact in working hours and out of normal hours. Contact details were easily accessible.

There was a chaperone policy readily available for staff to read. 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 nurse and health care assistants at the practice had received formal chaperone training and were used when one was requested by a patient or the GP. As there was only one male GP working at the practice staff ensured that patients were made aware of the availability of chaperones.

Are services safe?

Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Chaperone signs indicating their availability were visible in the reception area. All nursing staff had been trained to be a chaperone. Reception staff had received some awareness training.

The GP at the practice reviewed all test results and recorded relevant information in the patient record system. Where considered necessary the GP called patients personally or requested that reception staff make contact. Patients expecting test results could call the practice during the week at a set time. The practice had a system in place for identifying those patients who had not called for a result and where the test indicated that a follow-up appointment was necessary.

Staff spoken with were aware of whistleblowing procedures and felt they could raise any issue with the GP or practice manager and that it would be dealt with effectively. They were also aware of who to contact outside of the practice if there was a concern that they felt they could not raise with staff at the practice.

Medicines management

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

Vaccines were securely stored in a fridge dedicated for that purpose and were only accessible to authorised staff. Stocks were rotated regularly and fridge temperatures monitored and recorded. We looked at the records held and found this was taking place and that the fridge was operating between recommended temperature ranges. The vaccines we looked at were not being stored beyond their expiry date. Medicines received at the practice that required storage in a fridge were dealt with on arrival so they remained out of the fridge for as little time as possible.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines for clinical use were checked and were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had established a service for patients to pick up their dispensed prescriptions at a local chemist.

Patients who were elderly or housebound had their medicines delivered to them by the pharmacy direct to their home. All prescriptions were reviewed and signed by a GP before they were given to the patient.

The GP undertook regular reviews of medicines used by patients to ensure they were effective, necessary and not causing any health issues. The GP told us that it was their sole responsibility to carry out a prescription review and that they were aware of their patients conditions and when reviews were due. This involved speaking with patients personally and/or organising blood tests where necessary.

However although we found that reviews were being carried out effectively the system in use was a little ad hoc and relied on the knowledge of the GP about his patients rather than following a system. We discussed this with the practice on the day of the inspection and they have agreed to formalise their medicine review system into a written policy so that support staff and locums would be able to follow it, in the absence of the GP.

Cleanliness and infection control

The practice had a lead for infection control who had undertaken training to enable them to carry out the role. This was the practice nurse. All staff had role specific infection control training. An infection control policy was in place and available for staff to refer to if required.

An infection control audit had not taken place within the last two years. Guidance from the Department of Health recommends that a practice should produce an annual statement that includes a review of infection control audits for the year and subsequent actions and risk assessments undertaken for the prevention and control of infection. We discussed this with the practice on the day of our inspection and since our visit one has taken place which has been sent to us. This audit identified some minor issues and these were in the process of being actioned with a review date in three months' time. The audit identified that generally, infection control procedures were robust.

The practice had not undertaken a legionella risk assessment as required by health and safety legislation. Legionella is a term for particular bacteria which can contaminate water systems in buildings and can be harmful.

Are services safe?

The practice was following the guidance relating to the control of substances hazardous to health (COSHH). A contract was in place for a private company who undertook the cleaning of the practice.

Cleaning schedules were in place that included the frequency of cleaning and the materials to use. Checklists were in place and were being completed.

Clinical waste was stored safely and disposed of in line with guidance and an external contractor was employed for that purpose. We noted that an audit in 2013 of their handling of clinical waste identified that unsafe waste bins were in use. These had been replaced with those recommended by guidance.

We observed the premises to be visibly clean and tidy. There were adequate supplies of hand soaps, sanitising gels and hand towels available in treatment rooms and toilet facilities. Notices describing hand hygiene techniques were displayed around the practice.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Clinical staff had received inoculations against Hepatitis B and they received periodic blood tests to ensure it remained effective.

Equipment

Staff we spoke with told us they had the appropriate equipment and in sufficient quantities to enable them to carry out diagnostic examinations, assessments and treatments. We found that all electrical and medical equipment had been tested and calibrated in March 2015 and certificates were in place that reflected that the equipment used was in working order.

Equipment in use included weighing scales, spirometers, blood pressure measuring devices and a blood/sugar testing monitor. Also available for patients was a blood pressure monitoring device which was kept in the waiting room and patients were encouraged to use it.

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 ensuring that appropriate recruitment checks had been undertaken prior to

employment, including proof of identification, references, qualifications, registration with the appropriate professional body. The policy stated that all prospective staff were required to undertake a Disclosure and Barring Service (DBS) check. This is used to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We looked at five personal records of staff working at the practice. We found that there was a lack of consistency in relation to obtaining references, verifying identity, completing a formal induction process, undertaking Disclosure and Barring Service checks and record keeping. We did find that there was some evidence of courses having been attended with supporting certificates, that were in date, in place.

In particular we looked at the files of the most recent members of staff at the practice that had been employed in the last two years. We found that there was an inconsistent approach to the obtaining of references, disclosure and barring service checks and completion of an induction process.

We discussed this with the practice on the day of the inspection and were told that they had not obtained any written references for one particular member of staff, but had confirmed their suitability verbally with a previous employer. This was appropriate in the circumstances for this member of staff.

The practice manager was in the process of reducing their hours and was considering retirement. The practice had recognised this and was actively seeking a replacement for the role. In the short term two members of staff had agreed to take responsibility for a number of key areas so that the practice manager role was fulfilled, albeit that they were not looking to take on the practice manager role.

The practice occasionally used locum GPs and nurses and these were obtained through a local agency. There was an effective system in place to ensure that locums used were suitably qualified and experienced. We were told that the locum agency sent evidence that they were registered with their professional body and suitably qualified. They then received an induction when attending the practice to ensure they were familiar with the practice procedures and systems.

Are services safe?

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Where there were identified staff shortages due to annual leave, training, sickness or other absence, staff covered for each other. Staff we spoke with felt there were sufficient numbers of staff available to run the practice effectively and keep patients safe.

Monitoring safety and responding to risk

The practice had a health and safety policy and health and safety information was displayed within the practice for staff to read.

The practice had undertaken a health and safety risk assessment as required by current legislation. This identified the risks in the practice to staff and patients and the steps to take to reduce those risks. Staff were encouraged to report any issue that might affect safety. A health and safety audit had taken place at the practice to ensure risks were being minimised and the environment was safe. During our inspection we looked around the premises and did not identify any areas of concern.

The practice monitored those patients who did not collect their prescriptions to ensure that this did not adversely affect their health. This included an arrangement with a local chemist that returned uncollected prescriptions for review by the GP. If the practice felt that a patient was at risk of deteriorating health they would be contacted to check on their welfare.

Elderly patients taking vitamin supplements regularly such as vitamin injections were monitored to ensure they attended for them at the appropriate intervals. There was a system in place to monitor those who did not attend to ensure they were well.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that there were sufficient numbers of staff that had received training in basic life

support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Emergency medicines were available 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 also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Oxygen was available and stored correctly. A contract was in place that reflected that it had been tested and was being maintained.

Staff had received training in basic life support and this was monitored by the practice manager to ensure refresher courses were attended every three years. Staff spoken with were aware of the location of emergency medicines and equipment. Training included the use of a defibrillator and resuscitation methods.

The GP at the practice used an emergency medicines bag which they took with them when away from the practice. The GP assumed responsibility for ensuring it was stocked appropriately and that all medicines/items in use were within their expiry date. We checked the contents of the bag and found that they contained recommended emergency medicines and all were in date.

Staff had received fire safety training and were aware of evacuation procedures and how to use firefighting equipment such as fire extinguishers. Fire Marshalls had been appointed.

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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We found that assessments of patients took place in line with NICE guidelines. Where an assessment revealed a more complex diagnosis, patients were referred to specialists and other secondary care services in a timely manner and where urgent, often on the same day. Patients were supported to book a specialist of their choice.

There was an effective system in place to monitor national patient safety alerts. These were sent to the practice and reviewed by the GP who made appropriate clinical decisions. The information was then disseminated to the nurse and other staff if relevant to their role.

The practice nurse provided diagnostic consultations for patients with minor illnesses and injuries such as coughs and colds, ear infections and urinary tract infections. They did not issue prescriptions as they were not qualified to do so. Any issues that could not be dealt with by the nurse were referred to the GP for a consultation. This enabled the GP to see patients with the more complex needs. The nurse undertook child immunisations and cervical smear testing.

Management, monitoring and improving outcomes for people

The practice used the quality and outcomes framework (QOF) to monitor performance across key areas of healthcare. (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 e.g. diabetes and implementing preventative measures. The results are published annually).

The practice manager told us that performance could be improved at the practice in relation to the QOF if there was additional training for staff in relation to coding and the

functionality of their computerised record system. We were told that further training was being actioned in the near future. We were told that improvements in the coding of patients had already been made and that when reception staff booked patients in they would alert the GP or nurse that they were due for a review.

When we inspected the practice we looked at QOF data for the year to March 2014 and the current position for this year. The practice provided us with their most up to date data for the year end to March 2015. The practice recognised that in some areas of health monitoring, improvement was required but they were aware of the issues.

The nursing staff at the practice were responsible for monitoring the performance of the practice against the national programme of immunisations for children. Data available to us for the year ending March 2014 reflected that the practice was below the local average for the delivery of child immunisations for the ages of 12 months to five years. However the data for the current year ending 31 March 2015 reflected that of those eligible for immunisations, 90% had received them. This was an improvement on last year

The practice monitored those patients eligible for a cervical smear test. Patients eligible for a test were contacted if they did not attend for an appointment or if there was an adverse test result. The practice performance for the year end March 2014 was in line with the average for the local area.

One clinical audit we looked at related to cervical screening and the rate of inadequate smears having been taken that required patients to have re-attend for another one to be undertaken. This identified where the practice could make improvements. The analysis revealed that the rate of inadequate smears was low and remedial action was not required. A repeat audit then confirmed that standards were being maintained with a very low percentage of smears being inadequate (3.3%).

The nursing staff at the practice undertook regular checks on patients with long term conditions, such as diabetes, chronic obstructive pulmonary disease and asthma. Weekly clinics were held where patients could attend and receive advice, guidance and have their condition monitored.

Are services effective?

(for example, treatment is effective)

Data available to us for the year end March 2014 reflected that the practice was below the area average for the monitoring of patients with diabetes. This included blood/sugar tests, blood pressure monitoring and regular health reviews, including foot examinations. The practice was aware of this and was taking steps to improve the position. We were told that some checks took place at a local hospital and the practice had little control over whether patients attended there or not. The practice did accept that further improvements were still required if they were to achieve their targets in relation to QOF performance. They said that this was part of their improvement strategy for next year.

Patients suffering from asthma and chronic obstructive pulmonary disorder (COPD) were monitored and received an annual health check. Of those patients with asthma, 67% had received their review and with COPD 89% had received a review.

Patients suffering from poor mental health, dementia and those with learning disabilities were monitored at the practice and recorded on a register. The practice had achieved their targets for both these types of patient in providing annual health reviews for them.

The practice had a smoking cessation team in place. Smokers were identified through patient records and they were contacted and advised of the service available. The practice monitored their success rate and found that of those patients attending the smoking cessation clinic, 1% had ceased smoking. This equated to a total of 31 patients.

Mothers and babies received ante natal advice from the GP at the practice. They did not provide post natal services but these could be obtained from the community midwife at the local village clinic.

The practice monitored the A&E attendances of their patients and in particular those that were frequent attenders. They looked at the clinical reasons for the attendance and whether they could implement any interventions to avoid unnecessary use of the service.

The practice had a palliative care register for those patients that required end of life care. Regular multidisciplinary meetings took place to discuss the care and support needs of patients and their families. They described a good relationship with Macmillan nurses, the hospice nurse and consultants.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff training met the needs of patients and that it was being monitored. Some staff had received specialist training. For example the practice nurse was qualified in asthma management and infection control.

The GP was up to date with their yearly continuing professional development requirements and either had been revalidated or had a date for revalidation. The GP had recently had their annual appraisal. (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).

There was an annual appraisal process in place and all staff had received one when it was due. We looked at three staff files and found that annual appraisals had taken place. Staff spoken with said they were meaningful.

The practice had a training policy that outlined the provision of training for their staff. This stated that a training needs assessment would be discussed at annual appraisals and where relevant training was identified, staff would be supported to attend. This included attending in their own time when time off in lieu would be granted. This annual approach to planning for training needs reflected that training was being monitored at the practice and included an awareness of when staff were due to attend refresher training. This ensured that competency was maintained.

Staff spoken with told us that most of their training needs were being met and they felt supported and confirmed that annual appraisals were used to discuss their training needs. We looked at four staff files and found that training had been recorded and certificates of attendance reflected that training was current. The appraisal included discussing the training and development needs of staff and they were invited to complete a feedback form about their achievements and aspirations. An interview then took place, objectives and training needs agreed and a performance grading given.

The practice had recognised that the GP and other staff at the practice had not received sufficient training in the use of their computerised patient record system and training

Are services effective?

(for example, treatment is effective)

was in the process of being organised. This would enable staff to make better use of the system to identify patients more easily to ensure they received the care and treatment that was available to them and to meet healthcare targets.

The practice nurse told us they were encouraged to undertake their continuous professional development (CPD) to maintain their skill levels. Their personal file contained details of the number of hours they had undertaken in order to maintain their competency.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support 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. These were reviewed by a GP and then appropriate clinical decisions were made and recorded, then the patient records were updated by support staff.

When patients required a referral to a specialist a patient's summary was prepared that covered a brief history about the medical history of patient and the current diagnosis. This accompanied the referral letter for the information of the specialist.

The practice held quarterly multidisciplinary meetings to discuss patients with complex needs, such as those with end of life care needs, long-term conditions or at risk of their health deteriorating rapidly. Care and treatment plans were put in place to manage their condition and to reduce the risk of unnecessary hospital admissions.

Information sharing

The practice used an electronic patient record system to coordinate, document and manage patients' care. All staff were trained on the system but the practice accepted that staff required further training to enable the practice to make best use of it.

Patients were supported to use the select a hospital/specialist of their choice when there was a need to refer them for specialist treatment. This preference was then sent to a central referral point where the most appropriate clinical pathway was selected and the patient advised of the date of their appointment. Patients usually received the date of their appointment within two weeks of the referral.

The practice received information from the local GP out-of-hour's service when their patients had cause to use it. The record of the consultation was then placed on their electronic system and reviewed by the GP to assess whether a follow-up appointment was required.

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 in their practice.

There was a consent policy for staff to refer to that explained the different types of consent that could be given. Consent forms were available for some of the services provided at the practice. A consent form had also been introduced for parents/guardians to consent to their children receiving childhood immunisations.

The GP was aware of the need to undertake mental capacity assessments if the need arose and if necessary to consult with relatives and/or carers before making a decision in a patients' best interests if found to be lacking capacity.

Nursing staff administering vaccinations to children were aware that they needed to obtain consent from a person with the legal capacity to do so, such as a parent or guardian. Where there was doubt the procedure was delayed until the consent issue could be clarified.

Clinical and reception staff were aware of Gillick competence. This is where in some circumstances a child under the age of 16 can consent to receiving care and treatment without a parent/guardian being present. Where a child of this age was seen by a GP or nurse they were aware of the Gillick competence test, used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

The practice leaflet and website explained the types of health prevention that was available at the practice. This included lifestyle advice, counselling, symptom advice, travel immunisations, flu immunisation, cervical smear testing and breast cancer screening (mammography).

Are services effective?

(for example, treatment is effective)

The practice was pro-active in advertising the availability of flu vaccinations for the elderly and other patients eligible to receive them. They had identified a member of staff who were up to date on the IT system and aware of the various types of communication available. They made use of local advertising, letters to patients and contacted them by text and email. Reception staff were encouraged to obtain the most up to date communication information for each patient so they could contact as many patients as possible. The practice was performing in line with the national average for flu vaccinations for patients over the age of 65.

The practice offered a health check to all new patients registering with the practice. Any health concerns detected were followed up by referral to the GP. Health checks for the elderly were available including shingles vaccinations. Chlamydia screening was available for patients. Nursing staff provided smoking cessation, dietary and alcohol consumption advice.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice identified the patients eligible for this check and wrote to them advising them of the service. Health checks were also available for patients with a learning disability. Patients over 75 years of age had a named GP so they could receive continuity of care.

The practice offered a full range of immunisations for children. The practice was aware of those children eligible and was pro-active in achieving the national targets. Data

available to us for the year ending March 2014 reflected that in some areas of child immunisation the practice was below the local average and in other areas were above. They were aware of their performance and were taking steps to improve. They had put in place a system to follow-up and contact patients who did not attend for their immunisation. Improvements in the number of children receiving vaccinations had improved for this year ending March 2015.

The practice was pro-active in monitoring patients due for cervical smear tests. Patients were sent a letter centrally advising them that they should be tested and the practice were also informed. Patients failing to book appointments were contacted three times by letter by the practice to try and encourage them to attend. If they still did not attend further attempts were made either by phone or when attending the practice for other matters. Patient records were marked up accordingly so that they could be easily identified when they attended the practice. Data held by us reflected that for the year end March 2014, the practice were in line with other practices nationally for cervical screening uptake by patients.

A leaflet was available in the reception area that offered advice to those patients suffering from diabetes. This included facts about living with the condition, understanding diabetes and the importance of a healthy diet, exercise and regular blood/sugar monitoring.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Reception staff were aware of the need to maintain patient confidentiality. If telephoning patients to inform them of test results we were told that steps were taken to ensure they were speaking to the patient and not a friend/relative by confirming their identity. Where there was a need to leave a message, details about the nature of the call were not revealed and patients were just requested to call the practice.

The reception desk had a glass partition that could be closed when staff were making/receiving telephone calls from patients. This helped maintain confidentiality. We observed that reception staff were polite and courteous both in person with patients and when speaking with them on the telephone.

We spoke with three patients on the day of our inspection. They told us that staff were kind and caring and treated them with dignity and respect. Patients said their children were also well treated and spoken to in a way they understood.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 38 completed cards and all of them were positive about the service experienced. Patients said they felt the practice staff were kind and caring and treated them with dignity and respect.

Staff told us that consultations and treatments were carried out in the privacy of a consulting room. Patients were aware that they could request a chaperone if they felt they needed one. Chaperone signs were displayed in the reception area so that patients were made aware of their availability.

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

We reviewed the most recent data available for the practice on patient satisfaction from the national patient survey from July 2014. This reflected that 72% of patients felt that the GPs treated them with care and concern and 82% said the same of the nurses at the practice.

Care planning and involvement in decisions about care and treatment

The national patient survey in July 2014 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Of the patients responding to the questionnaire, 89% said that the GP was good at listening to them, 70% said that the GP was good at explaining tests and treatments to them and 73% said the GP was good at involving them in the decisions about their treatment.

Patients we spoke with on the day of our inspection told us that explanations about their diagnosis, care and treatment were clearly explained to them and they felt involved in decision making about the care and treatment they received. They 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 supported these views.

Patient/carer support to cope emotionally with care and treatment

Staff told us that if families had suffered bereavement they were offered an appointment with the GP, provided with support and signposted to external support organisations. It was the practice policy to send a condolence card. A policy was in place that identified the action the practice would take in the event of bereavement.

The practice identified those persons with caring responsibilities and was aware of their needs. The practice's computer system alerted GPs if a patient was a carer. Carers were offered health checks and flu vaccinations. Information was available in the patient waiting room about support groups and organisations that could help carers.

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 its' patient population and was responsive to their needs. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Patients suffering from poor mental health were identified and offered appropriate support and guidance. They were recorded on a register and their condition monitored. A mental health counselling service attended each week and used a room at the practice to counsel patients suffering from poor mental health. This enabled the practice to refer their own patients to this service so they did not have to travel too far.

Patients with dementia received an annual health check and were recorded on a register and their condition monitored. At the time of our inspection all of the dementia patients on the register had received their annual health check.

The practice monitored those patients assessed to be frail or with palliative care needs to put care in place to avoid an unplanned hospital admission. Patients were recorded on a register and other healthcare professionals were involved in the planning of their care and treatment. This included liaison with Macmillan nurses, social workers and community matrons. Multidisciplinary meetings took place on an informal basis due to the low numbers of patients on the register. Minutes of these meetings were not recorded.

The practice nurse was able to undertake consultations for patients suffering from minor illnesses. This allowed the GPs to concentrate on patients with more complex needs. They were not qualified to issue prescriptions so any health need requiring any medicine was referred to the GP.

The practice monitored patients with long-term conditions such as chronic pulmonary obstructive disorder (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections), diabetes and asthma. Regular health checks were available for them which included

lifestyle advice to support them to manage their condition. At the time of our inspection, the percentage of patients on their registers who had received their annual health checks were as follows; diabetes 80%, COPD 89% and asthma 67%.

The nursing team provided advice on smoking cessation, diet and exercise, alcohol consumption and cervical smear testing. They also provided child immunisations in line with the national immunisation programme and, at the time of our inspection, 90% of children registered at the practice had received their immunisations.

Patients could obtain their test results on two days of the week in the afternoons and could speak with a nurse if they wished. A system was in place to contact patients who had not called to obtain them if an adverse result had been received that required additional clinical input.

The practice had a patient participation group (PPG). They were small in number but met with the practice manager. We were told that their ideas were sought about improvements to the practice and patient surveys discussed with them. A Patient Participation Group is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Tackling inequity and promoting equality

The premises and services had been adapted to meet the needs of patients with disabilities. The practice benefited from a large private car park for the use of patients and access to the surgery was made easier with the availability of a ramp. The reception, waiting room area and consultation rooms were spacious and could accommodate wheelchair users and those with limited mobility. The practice had a toilet for the disabled.

The practice had access to online and telephone translation services but there had not been a requirement to use them. The practice welcomed patients who were travellers or who were homeless but at the time of our inspection none were registered there.

Access to the service

The GP held surgeries on each day of the week in the mornings and afternoons. The morning surgery began at 8.30am and finished at 10.40 am. Afternoon surgeries started at 4pm and finished at 5.30pm. There was one late night each week on a Wednesday until 8pm. The nurse was available at the same times throughout the week. The practice was closed at weekends.

Are services responsive to people's needs?

(for example, to feedback?)

Each day there were five bookable morning and afternoon appointments with the GP and nurse. Patients could book appointments up to six weeks in advance. Two emergency appointments were available each day. Priority was given to children, the elderly or vulnerable adults. After the morning surgery the GP conducted telephone consultations and home visits for those unable to attend the surgery in person.

The practice leaflet explained the appointment system to patients and this was also made clear on the practice website, including how to obtain a home visit.

The practice was aware of the need to offer suitable appointment times for school children, the working population and the elderly and adopted a flexible approach to try and meet patient needs. Appointments were available one evening each week on a Wednesday until 8pm but it was not being used as much as expected despite the efforts of the practice to advertise it in the surgery and on their website.

The practice offered longer appointments for patients with learning disabilities and for those with long-term conditions. This also included appointments with a named GP or nurse.

Information was available so that patients were aware of how obtain urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had conducted an audit on the number of patients that did not attend for their appointments. To reduce the numbers failing to attend they had introduced a text message reminder system. The effect of this had not yet been measured at the time of our inspection.

The most recent practice patient survey revealed that patients were satisfied with the appointment system.

Data from the national patient survey from July 2014 reflected that 91% of patients that responded found it easy to get through to the practice by phone, 76% described their experience of obtaining an appointment was good and 94% were able to get an appointment that was convenient to them.

Patients spoken with and CQC comment cards reviewed reflected that patients were satisfied with the appointment system. They confirmed that they could see a GP on the same day if they needed to.

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. Details of how to make a complaint were included in the practice leaflet. Patients could complete a form on the practice website and submit their concerns by email.

The responsibility for handling complaints was allocated to the practice manager. The GP at the practice was notified if the complaint related to a clinical matter, otherwise it was left to the practice manager to conduct an investigation and respond appropriately to the complainant.

We looked at the record of three complaints that had been received in the last 12 months and found that they had been investigated and steps taken to resolve the matter with the complainant.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. Their aims and objectives were made clear in their statement of purpose and these included providing safe healthcare for their patients, patient involvement in decisions, development of their staff and support for patients to help them to make healthy lifestyle choices and to access the care that met their needs.

The practice also had a business development plan which had been updated in October 2014. This document detailed the practice objectives including an action plan and timescales. Included in the objectives was their Quality and Outcomes Framework (QOF) performance, patient services, the creation of a practice intranet, identification of funding streams and establishing a patient forum. (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 e.g. diabetes and implementing preventative measures. The results are published annually).

We spoke with several members of staff on the day of the inspection and they were aware of the aims and objectives of the practice and felt part of a team that were working towards achieving them. Staff knew what their responsibilities were in relation to the objectives and how their role linked to them. They told us that they felt involved in the vision and future of the practice.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. This included infection control, safeguarding, information governance, and complaints. Staff spoken with were all clear about their own roles and responsibilities and felt valued. They knew who to go to in the practice with any concerns.

The GP at the practice was responsible for oversight of all issues relating to the management of the practice, supported by the practice manager. In the last 12 months both had been absent from work for an extended period of time and this had affected the performance of the practice.

We were told that this had put a strain on the practice and it had been difficult to maintain governance arrangements. Since the return of the GP and the practice manager they had recognised where improvements were required and were implementing them.

Clinical and non-clinical meetings were taking place but minutes were not being recorded. This meant that we could not be assured that governance issues were being discussed at these meetings as there was no audit trail to clearly document that these had taken place. This included an audit trail in relation to areas for improvement that required action being taken.

The practice had a range of policies and procedures in place to set standards and support staff. These included child protection, infection control, patient confidentiality, consent and health and safety. Staff we spoke with had ready access to them to support them in their roles.

A member of staff had been allocated the role of audit clerk and they had received audit training in the past. The practice had undertaken a number of clinical and non-clinical audits to monitor the services they provided.

There were both clinical and non-clinical audits being undertaken at the practice. One clinical audit we looked at related to cervical screening and their rate of inadequate smears having been taken that required patients to re-attend for another to be undertaken. This audit reflected that the quality of smears taken was satisfactory.

We looked at a non-clinical audit they had conducted in relation to their handling of clinical waste. This took place in 2013. It reflected that they were complying with their clinical waste policy but had identified two areas for improvement. These had been actioned.

The practice had carried out an audit in relation to the number of patients who failed to attend for their appointment. The period examined was the year commencing 01 April 2014 and ending 31 March 2015. They found that a high number of patients did not attend for their appointment. They have put an action plan in place to reduce the number failing to attend. This included publicising the results on their reception notice board and website, use of text message reminders and general education of patients so they could understand the effect

Are services well-led?

Good 

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

of the issues on other patients wishing to obtain appointments. A further audit has been planned for three months' time to assess whether any improvements have been made.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice up to the year end of March 2014 reflected that there was some room to improve to achieve some of the targets. The practice was aware of this and had employed a new member of staff whose responsibility was performance monitoring at the practice. We found that data for this year had improved and they were aware of the areas to focus on. Although minutes were not being recorded, we were assured that practice performance was discussed at management meetings.

Leadership, openness and transparency

The practice was managed by the GP and the practice manager. The practice manager had recently had an extended leave of absence from the practice and wished to reduce their hours considerably. Another member of staff was acting as the deputy practice manager in their absence in addition to undertaking their own role. The practice had not identified anyone internally who wished to take on the role on a permanent basis in the future but they were looking to identify a suitable candidate externally.

We were told that the practice manager/deputy met with the GP on a weekly basis to discuss management issues. These meetings were not formally recorded. There were also occasional lunchtime meetings when the need arose, but no records had been kept.

We were told that staff meetings took place every three months but no records had been kept and they were not minuted. We were told that due to the extended absence of the practice manager the meetings routine had lapsed and they had not taken place recently. Minutes of meetings prior to the absence had not been recorded.

Staff we spoke with confirmed that staff meetings took place every three months. They told us they felt part of the practice and they worked as a team. They told us that they were supported and their ideas for improvement were sought but these had not been recorded. They had been made aware of significant events, safety issues and

complaints and the learning from them and they were asked to contribute ideas to prevent reoccurrences. They said there was a no blame culture at the practice and a culture of openness.

We found therefore that although the GP and practice manager told us that various meetings took place at the practice, there was no supporting evidence to confirm this apart from what we were told by staff members that we interviewed. Due to the absence of minutes the practice was unable to evidence through an audit trail, that learning had been identified and improvements made.

We found that staff appraisals, objectives and job descriptions were linked to the vision and values of the practice. Staff told us they were valued and supported with their training and development needs.

Seeking and acting on feedback from patients, public and staff

The practice had a patient participation group (PPG) that was set up towards the end of 2014. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG consisted of seven members and one meeting has been held so far. The practice website was being used to notify patients of the existence of the PPG and used to invite other patients to join it or to volunteer to contribute ideas by email as part of a virtual PPG. They had identified that the group was not particularly representative of the patient population and were looking to recruit more members in a wider age range and from ethnic minorities.

The PPG met in December 2014 with the practice manager, minutes were recorded and posted on their website and in the practice. The PPG were being consulted about the patient survey and their views on improvements that could be made at the practice. The PPG was planning to link in with other local practices to identify areas for improvement and share good practice.

A suggestion /comments box was available in reception that patients could use if they wished, to provide feedback about the services provided.

Staff made use of a note book to record suggestions and ideas for improvements. These were discussed at team

Are services well-led?

Good 

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

meetings but minutes were not recorded. There was an absence of evidence that reflected that the views of staff about the services provided at the practice were regularly sought.

The practice had conducted a patient survey between the period 01 October 2014 and 30 November 2014.

Questionnaires were sent to patients and 50 replies were received. Patients were asked to grade specific services provided including the quality of the GP, nurses and reception staff. Questions covered areas such as explanations and involvement in decisions about care and treatment, time available with the GP, ability to see the GP of choice, requesting repeat prescriptions and obtaining test results.

We looked at the results of the survey and found that in general, patients were satisfied with the services provided. The majority of the patients rated the practice as either good, very good or excellent. The survey results were discussed at a PPG meeting in December 2014 and an action plan implemented. However the action plan was not available for us to view and it had not been publicised on the website or in the practice.

The NHS conducts independent surveys of patients about their practice annually. The last survey took place in July 2014 and 263 questionnaires were sent out to patients. The return rate was 43%. There were a number of areas where the practice exceeded average satisfaction rates in the local area including the punctuality of GPs with appointment times, getting through on the phone and obtaining an appointment. They were below average for the areas in relation to explanations of care and treatment provided by the GP, patients who were prepared to recommend the practice and listening to patients.

The practice had recently implemented the NHS Friends and Family test for the months of January, February and

March 2015. This test provides patients with the opportunity to provide feedback on their experience at the practice. It asks patients if they would recommend the services they have used and offers a range of responses. It provides a mechanism to offer both good and poor patient experience.

The majority of replies received over the three month period indicated that patients would be extremely likely or likely to recommend the practice. Those patients who chose to make brief comments were very positive about the GP, the appointment system and the friendliness of the staff, amongst other areas.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that the GP was available for advice and guidance when required.

Training needs had been identified and organised so that staff could improve on the way they delivered services. The practice had recognised that staff required additional training on their computerised record system to get best use out of it. Training was being organised for the near future.

The practice had completed reviews of significant events, accidents and other incidents and shared with staff at meetings or informally, although minutes had not been recorded. All staff had been trained in their computerised electronic health record system and used it frequently to share learning and good practice.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>We found that the registered person had not protected against the risks of inappropriate care and treatment because the practice did not have effective recruitment procedures.</p> <p>In particular, there was an absence of a consistent approach to obtaining references, verifying identity, completing a formal induction process, undertaking Disclosure and Barring Service checks and record keeping.</p> <p>This was in breach of regulation 21(a)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>