Springwell House

Quality Report

Springwell House, Durham Road,
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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?	Inadequate
Are services effective?	Requires improvement
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

We carried out an announced comprehensive inspection at Springwell House 16 April 2015. Overall, the practice is rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Arrangements to manage patient safety and evidence a safe track record were in early stages of development and further implementation was required to ensure the practice could demonstrate a safe track record over the long term. Learning from safety information was not systematic and detailed records were not maintained to evidence how the practice had learnt from this information.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Clinical and internal audits were not used effectively to improve quality.
- The practice had scored very well on clinical indicators within the quality outcomes framework (QOF). They achieved 99.1% for the year 2013/14, which was above the average in England of 96.47%.
- The practice had a system in place for handling complaints and concerns. The practice did not have a complaints leaflet or other patient information which set out the process they should follow, and who patients could go to if they needed support in making a complaint.
- Patients said they found it easy to make an appointment and urgent same-day access was available.

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

Importantly, the provider must:

- Put in place appropriate arrangements to maintain a clean environment, and assess the risk, detect, prevent and control the spread of infections.

Summary of findings

- Ensure there is appropriate equipment and medicines to provide treatment to patients in a medical emergency.
- Ensure arrangements in place support the right to privacy for patients and the security and confidentiality of medical records.

In addition, the provider should:

- Develop a clear vision and strategy for the practice, which is shared by all staff. This should include how the practice plans for quality improvements.
- Improve the approach to audit to ensure standards are clearly defined, and there is a clear link between audits and improvement in the quality of the service.
- Make sure there are arrangements in place for those patients who wish to see a female GP.

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?

Inadequate

The practice is rated as inadequate for providing safe services. We found that arrangements to manage patient safety and evidence a safe track record were in early stages of development. Further implementation was required to ensure the practice could demonstrate a safe track record over the long term. Learning from safety information was not systematic and detailed records were not maintained to evidence how the practice had learnt from this information.

There were arrangements in place to ensure patients were safeguarded from the risk of abuse when using the service. There were arrangements in place to ensure the safe management of medicines. The practice did not have in place appropriate arrangements to ensure the practice premises and equipment were kept clean, and the risk of infections was reduced. The practice was not sufficiently prepared to enable them to respond to medical emergencies.

Are services effective?

Requires improvement

The practice is rated as require improvement for providing effective services. There were arrangements in place for clinicians to access National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. However, the practice was unable to demonstrate how they had made changes as a result of these. We found there was insufficient detail included within the clinical audits to determine the standards being monitored. Although some demonstrated the complete audit cycle had taken place, most did not. We found audit was not used effectively to improve quality.

Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. However, rates of child hood immunisations were lower than comparators. We found the practice was supporting people to live healthier lives through health promotion and prevention of ill health.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there were areas where improvement should be made.

Data showed that patients rated the practice lower than others for some aspects of care. We found the practice had not taken appropriate steps in some areas to protect the privacy and dignity of patients. Information to help patients understand the services available was easy to understand.

Summary of findings

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. They reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice website was very basic and did not include some important information to help patients access the service. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Patients were not offered choice in the gender of GP they wished to consult. Both GPs within the practice were male and there were no alternative arrangements available for those patients who wished to see a female GP.

The practice had a system in place for handling complaints and concerns. However, the practice did not have a complaints leaflet or other patient information which set out the process they should follow, and who patients could go to if they needed support in making a complaint. There was also no information available to patients which set out what they could do if they remained unsatisfied with the way their complaint had been handled. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services, as there were areas where improvement should be made. The practice did not have a formal business plan in place. We found there was a lack of strategic leadership and vision within the practice. Audits had been carried out, but these did not identify and lead to improvements in the quality of the service offered.

There was a management structure in place, which set out accountabilities and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk, however we found that arrangements to learn from incidents and events were in early stages of development and further implementation was required to ensure the practice could demonstrate a proactive and learning culture.

The practice proactively sought feedback from staff and patients, which they acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. There were aspects of the practice which were rated as requires improvement or inadequate and these related to all population groups.

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 their population and had a range of enhanced services, for example, in dementia and end of life care. They were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The managers of three local care homes for older people told us the practice responded well to residents who were patients of the practice. They told us the practice responded quickly to requests to undertake visits to the homes, and communication of care and treatment needs was effective.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. There were aspects of the practice which were rated as requires improvement or inadequate and these related to all population groups.

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. These patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nationally reported data showed the practice achieved 100% of the points available for Quality and Outcomes Framework (QOF) for the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy.

The practice ensured timely follow-up of patients with long-term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There were aspects of the practice which were rated as requires improvement or inadequate and these related to all population groups.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered a full range of immunisations for children. However, the practice performed lower than other practices within the local CCG on rates for a number of child hood vaccinations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Cervical screening rates for women aged 25-64 were slightly below the national average at 81.4%, compared to 81.9%. QOF data demonstrated the practice performed well in relation to contraception and maternity services.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). There were aspects of the practice which were rated as requires improvement or inadequate and these related to all population groups.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. The practice had achieved good results on indicators relating to access within the National GP Patient Survey. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. There were aspects of the practice which were rated as requires improvement or inadequate and these related to all population groups.

Summary of findings

The practice held a register of patients living in vulnerable circumstances including those who misuse substances and those with a learning disability. They carried out annual health checks for people with a learning disability. They offered longer appointments for those who required them.

They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people with poor mental health (including patients with dementia). There were aspects of the practice which were rated as requires improvement or inadequate and these related to all population groups.

The practice held a register of patients experiencing poor mental health and there was evidence they carried out annual health checks for these patients. The practice regularly worked with the multi-disciplinary teams in case management of people experiencing poor mental health, including those with dementia. There was a system in place to identify patients who might be at risk of developing dementia and also to review their needs. For example, 88.9% of patients on the dementia register had their care reviewed in a face-to-face interview in the preceding 12 months. (This was 4.9 percentage points above CCG Average and 5.1 above the England Average). Staff told us this helped to ensure this group of patients received appropriate care and support, and clinicians were aware of their needs.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. They had systems in place to follow up patients who had attended Accident and Emergency (A&E). Staff had received training on how to care for people with dementia.

Summary of findings

What people who use the service say

We spoke with six patients and two family carers during the inspection. We were unable to speak with any patients from the virtual Patient Participation Group as the practice told us most were not available at the time of the inspection. The inspector tried to contact those who were available on a number of occasions, but was unable to make contact.

The majority of patients told us they were happy with the care, treatment and service they had received at the practice. They told us staff were normally friendly and respectful of them. One patient did share some concerns with us, but told us after their consultation they were happy with the action agreed. The patients we spoke with told us when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand. Patients told us they could get an appointment easily, and this was always quickly if there was an urgent need.

We reviewed eight CQC comment cards completed by patients prior to the inspection. Six of these were wholly positive commenting on the helpfulness of staff and the good service they received. The two remaining comment cards also commented on the good service they received. However, they also included negative feedback. One commented that they would like to see more evening appointments to meet the needs of those patients who worked during the day. The other commented on a recent experience of poor customer service, which they felt was unusual within the practice.

The latest GP Patient Survey published in 2015 showed although the majority of patients were satisfied with their overall experience of the GP surgery (at 80%), this was lower than the local Clinical Commissioning Group (CCG) average (at 88%) and England average (at 85%).

The three responses to questions where the practice performed the best when compared to other local practices were:

- 81% of respondents with a preferred GP usually get to see or speak to that GP (Local CCG average: 62%).
- 99% of respondents find it easy to get through to this surgery by phone(Local CCG average: 81%).
- 85% of respondents describe their experience of making an appointment as good(Local CCG average: 77%).

The three responses to questions where the practice performed least well when compared to other local practices were:

- 55% of respondents usually wait 15 minutes or less after their appointment time to be seen (Local CCG average: 70%).
- 76% of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments (Local CCG average: 83%).
- 76% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care (Local CCG average: 75%).

These results were based on 118 surveys that were returned from a total of 322 sent out; a response rate of 37%.

Areas for improvement

Action the service MUST take to improve

- Put in place appropriate arrangements to maintain a clean environment, and assess the risk, detect, prevent and control the spread of infections.
- Ensure there is appropriate equipment and medicines to provide treatment to patients in a medical emergency.
- Ensure arrangements in place support the right to privacy for patients and the security of medical records.

Action the service SHOULD take to improve

- Develop a clear vision and strategy for the practice, which is shared by all staff. This should include how the practice plans for quality improvements.

Summary of findings

- Improve the approach to audit to ensure standards are clearly defined, and there is a clear link between audits and improvement in the quality of the service.
- Make sure there are arrangements in place for those patients who wish to see a female GP.

Springwell House

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Lead Inspector.** The team included a GP and a specialist advisor with experience of practice nursing.

Background to Springwell House

The Springwell House practice is located in Sunderland on the A690, Durham Road, a main road leading to Sunderland city centre. The practice provides services to around 2000 patients. The practice provides services from the following address, which we visited during this inspection:

Springwell House, Durham Road, North Moor, Sunderland, Tyne and Wear, SR3 1RN.

The practice provides services to patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

The practice has one lead GP who owns the practice. There is also a locum GP, a practice nurse, a healthcare assistant, a practice manager and two administrative support staff. Both GPs are male.

The practice is a single story building with fully accessible treatment and consultation rooms for patients with mobility needs. There is a ramp leading up to the front of the building for patients in wheelchairs and those who have difficulty using stairs. There is a disabled WC. There is nearby parking on the street.

Surgery opening times are Monday 7:30am to 6pm, Tuesday to Friday 8:30am to 6pm.

The service for patients requiring urgent medical attention out of hours is provided by the 111 service and Nestor Primecare Primary Care – Sunderland.

They serve an area with higher levels of deprivation affecting children and people aged 65 and over, when compared to other practices in the local CCG, and the England average. The practice's population includes less patients aged under 18 years, and more patients aged 65 and over, than other practices in the local CCG area.

The average male life expectancy is 77 years and the average female life expectancy is 81. Both of these are two years lower than the England average. The number of patients reporting with a long-standing health condition is higher than the national average (practice population 60.5% compared to a national average of 54.0%). The number of patients with health-related problems in daily life is slightly higher than the national average (51.1% compared to 48.8% nationally). There are a higher number of patients with caring responsibilities at 20.7% compared to 18.2% nationally.

Why we carried out this inspection

We inspected this service as part of our new 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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. Our findings during the inspection did not support this.

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 16 April 2015. We spoke with six patients, the lead GP and six members of staff. We spoke with and interviewed two GPs, the practice manager, a practice nurse, a healthcare assistant and two staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed eight CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services. We spoke with the managers of three local care homes, where the practice provided services to some of their residents.

Inadequate

Are services safe?

Our findings

Safe track record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how this practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in July 2014 and the Quality Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety. Our findings during the inspection did not support this.

The practice could not provide us with evidence they routinely used to identify risks and improve quality in relation to patient safety. For example, staff we spoke with, including the GPs and practice nurse told us they received national patient safety alerts. The Lead GP and practice manager told us they forwarded alerts they received to the staff who needed to see them, however they did not keep a record of alerts received or disseminated. When asked if there was evidence of how they had taken action following an alert, the lead GP said although action was taken they did not routinely document and store evidence of this.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. They told us incidents of safety were discussed and learning was approached with an open culture.

The practice used the local Clinical Commissioning Group (CCG) wide Safeguard Incident Reporting Management System (SIRMS). This was used to record incidents and provide feedback on patient's experiences of care within other services in the local area. They showed us an example of a serious prescribing error made by a GP within the practice which had been identified by a local pharmacy before the medicine was dispensed. This had been reported via the SIRMs system. The practice had taken some action to address these concerns. Actions included greying out the option to pick a high dose on the practice computer system for morphine. This did not stop the dose from being picked, but provided a visual reminder not to prescribe the dose. They also put in place arrangements to ensure better communication with the district nurses when end of life care medicines were to be prescribed.

We reviewed safety records and incident reports. We saw these were discussed at monthly staff meetings. The practice could not provide any evidence to confirm that themes and trends within incidents and matters of safety were routinely reviewed.

We found that arrangements to manage patient safety and evidence a safe track record were in early stages of development and further structured implementation was required to ensure the practice could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

While the practice had a process in place for reporting events, incidents and accidents, it was evident the system did not effectively consider in enough detail the potential learning from these to lead to continuous improvement in patient safety.

We looked at records of incidents that had been logged over the last year, of which there were three in total. The latest recorded incident was recorded in February 2015. We spoke with staff, including the practice manager, the practice nurse and administrative staff who all described the same reporting process to us. The process was to report all events, incident and accidents to the practice manager or the lead GP if they were unavailable. Managers within the practice discussed each incident and documented the outcome of the significant event and learning identified on the significant events template. We found the documented significant events lacked clinical detail, which made it difficult to quantify from the records the level of risk or harm. For example, the two significant events relating to medicine prescribing errors did not include the medicine involved or the dose prescribed.

For those events recorded, there were notes referring to actions to be taken, but there was no evidence provided to us to show that significant events were analysed over time or that the effectiveness of learning actions had been reviewed.

We found the analysis and identified learning focussed on superficial actions and did not consider the systemic learning they could take from these. For example, an incident relating to incorrect disposal of patient identifiable

information did not consider the antecedent actions or reasons behind the error. The learning identified was for all staff to shred any patient information when it was no longer needed. However, as the incident analysis did not include reasons as to why the error occurred in the first place it was difficult to determine if this action was sufficient to address concerns raised. There was little evidence of learning from events being shared with staff or the patients involved.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received role specific training on safeguarding. We saw evidence that one GP had received the higher level of training for safeguarding children (Level 3) and the other GP was in the process of arranging training to this level.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, record safeguarding concerns and contact the relevant agencies in working hours and out-of-normal hours. Contact details were easily accessible within practice policies and procedures. There were also safeguarding protocols displayed in the reception and administration team office areas for staff to refer to.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans or looked after children. 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 practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at accident and emergency departments (A&E).

There was a chaperone policy, which was available to staff. (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). We saw this was also advertised in the waiting room and consulting rooms. The health care assistant and a member of reception staff acted as a chaperone. They had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Appropriate police records checks, called Disclosure and Barring Record (DBS) checks had been carried out for those staff undertaking chaperone duties.

Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

We checked vaccines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a process for checking medicines were kept at the required temperatures and this was being followed by the practice staff. This ensured the medicines in the fridges were safe to use.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. This included the supply of emergency medicines kept by the practice. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions for most medicines administered and evidence that nurses had received appropriate training to administer vaccines. There was one medicine which the nurse had recently started to administer where a direction was not in place. The practice nurse said this had been missed and they would take immediate action to ensure this was put in place. In the meantime, the practice manager assured us this medicine would only be administered following prescribing by a GP.

Inadequate

Are services safe?

Patients were able to order repeat prescriptions using a variety of ways such as by telephone, online and by post. There was no information available on the practice website telling patients how they could request repeat prescriptions. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions.

A system was in place which helped to ensure patients who were receiving prescribed medicines were regularly reviewed. The GP we spoke with told us these reviews were carried out at least annually.

Cleanliness and infection control

We observed the premises to be clean and tidy, and areas of the practice had recently been redecorated as part of a refurbishment. Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Our findings did not support this and we found there were concerns in a number of areas.

The practice employed cleaners who attended the practice twice a week. They were supported in their role with cleaning schedules, which set out which tasks should be carried out. However, we were concerned that cleaning twice a week was not sufficient to ensure an environment that was clean and free from infections.

We checked with the practice manager and other staff whether any cleaning was carried out on the days cleaners did not attend the practice, for example, in patient and staff toilet areas or within the reception area. They confirmed no cleaning was carried out in these areas over above what was set out in the cleaning schedule. The national specifications for cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises states that frequency of cleaning should be based on the functional use of the area to be cleaned; the elements within the room (such as equipment, furniture and fitting); and an assessment of risk. It gives suggested frequency for things such as hard flooring, low surfaces, toilets and sinks to be cleaned daily based on the risks they present.

We noted there were two full sharps boxes stored on the floor of the treatment room. Practice staff told us they were unaware these were there, but thought they had probably been left by district nurses who regularly used that room.

We noted there were no sinks available in the practice other than those intended for hand washing, either in clinical rooms or in the staff and patient toilet areas. We asked the practice manager where cleaners and other staff obtained water for cleaning tasks. She confirmed this was from clinical sinks.

We found the cleaning schedule did not include tasks which we would expect to see to provide assurance that the environment was clean and free from infection. For example, it did not include cleaning of the privacy screens used in treatment and consultation rooms. We asked the practice manager and other staff if they had any evidence the privacy screens were cleaned on a regular basis. They confirmed they could not provide evidence of this.

The practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. We noted the practice did not have sanitary bins within patient and staff areas for the removal of sanitary wear and nappies. The practice manager confirmed there was no sanitary waste contract in place.

Practice staff told us there was nowhere to store bagged clinical waste when bins were full. They told us this was stored in the corridor to the back of the practice, near to the patient toilet. There were no waste bags stored here at the time of the inspection. However, we were concerned if waste was stored this way whilst the practice was open; this presented an infection control risk to patients and especially younger children who would not understand the risks.

There was no evidence that staff had attended infection control training in the staff training records we looked at. We spoke with the practice nurse and the practice manager about this. Both told us that training was to be arranged for the nurse, with the intention they would then cascade this information to other staff.

We found a number of out of date syringes of different gauges, swabs and steri-strips within treatment rooms, some of which had gone out of date in April 2012. We brought this to the attention staff. They told us one of the treatment rooms was used predominately by the district nurses and they had expected they would keep check of

stock rotation and remove any out of date stock. We asked who was responsible for ordering this stock. They confirmed the practice ordered all stock for the practice. We were concerned this stock could be used, placing patients at risk of infection. Stock of this type can no longer be considered sterile as they are past their use by date. When this was highlighted to the practice nurse they told us they would take action to dispose of these.

An infection control policy and procedures were in place and they covered a range of key areas such as, for example, obtaining specimens. These provided staff with guidance about the standards of hygiene they were expected to follow and enabled them to plan and implement measures to control infection.

We asked the practice manager if they could show us any evidence to demonstrate the provider had completed any infection prevention and control audits or monitoring activity. They provided us with an audit that had been carried out in January 2015 by the practice manager. We found this audit failed to pick up the concerns we had identified during this inspection.

The practice confirmed they did not have a legionella risk assessment in place at the time of the inspection. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). The practice contacted us after the inspection to inform us they had made arrangements for the local water company to carry out a legionella risk assessment and provided us with the date this was due to take place.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We saw records confirming, where appropriate, the calibration of equipment had been regularly carried out.

Practice staff monitored the safety of the building to ensure patients were not put at risk. Regular checks of fire equipment had taken place. For example, an up-to-date fire risk assessment was in place. Weekly fire alarm tests were carried out by staff but these were not documented. The practice had an evacuation plan which informed staff how the building should be evacuated in the event of an emergency. There was no record of fire drills taking place. The practice manager told us a fire drill had taken place within the last year, but this had not been documented.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Some of the records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, for the practice nurse not all recruitment checks were documented. A DBS check had been undertaken for this staff member, but this was carried out three months after the staff member came into post.

The practice manager routinely checked the professional registration status of employed GPs and nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out where staff were permanently employed by the practice.

The practice did not employ locums. Instead GP practices in the locality worked in a group to provide GP cover for each other for annual leave and other absences. The practice did not have in place a process to check GPs providing cover were suitable and appropriately registered. For example, checking they were on the National Performers list or registered with the GMC. (The National Performers list provides assurance that GPs practising in the NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service and the NHS Litigation Authority.) The practice manager told us this was done on trust, with an expectation that each practice had their own assurance processes to ensure GPs were suitable and safe to work as a GP.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. Staff told us there were effective arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover

each other's annual leave. Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Staff told us there were usually enough staff to maintain the smooth running of the practice and keep patients safe.

Monitoring safety and responding to risk

We saw that staff were able to identify and respond to changing risks to patients. For example, a risk assessment screening tool had been used to identify patients at risk of an unplanned admission to hospital. Steps were being taken to complete emergency care plans to help prevent older patients and patients with long-term conditions experience unnecessary admissions into hospital. Information about patients with palliative care needs had been entered onto an electronic system which provided emergency professionals and out-of-hours clinical staff with access to information about how best to meet their needs.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. The practice had a health and safety policy. The practice manager showed us a number of risk assessments which had been developed and undertaken; including fire and health and safety risk assessments. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and was able to plan mitigating action to reduce the probability of harm.

Practice staff told us the hot water boiler for the practice was situated in the house next door. This was owned by the lead GP. However, this property had recently been rented out. There was no risk assessment in place to show the practice had considered the risks this presented. For example, the risk the practice would be unable to access the boiler in an emergency if it was to breakdown and the tenant was absent from the property.

Arrangements to deal with emergencies and major incidents

We found the practice was not sufficiently prepared to enable them to respond to medical emergencies. The practice did not have appropriate emergency medical equipment and medicines to allow them to respond to risks of this type. There was no oxygen or defibrillator (used to attempt to restart a person's heart in an emergency) available within the practice premises. Staff told us if a patient attended the practice with a medical emergency they would call emergency services, and as a small urban practice this would arrive quickly. However, they had failed to complete a detailed risk assessment in relation to this. In deciding what medical equipment was required they had failed to recognise that quick action significantly reduces the risk and can save lives, where even a small delay in receiving immediate medical assistance can impact on survivability.

The practice had three emergency medicines available within their emergency medicines kit. This included adrenaline (which can be used to treat anaphylaxis); hydrocortisone (for treating asthma or recurrent anaphylaxis); and, salbutamol (for treating asthma). We saw records to show the medicines held were checked they were in date and safe to use, then replaced in line with dates of expiry.

There was no documented rationale behind the decisions made with regards to which medicines to keep. The practice did not have access to antibiotics for treating suspected bacterial meningitis; medicines for relieving severe pain, chest pain of possible cardiac origin or epileptic fits. Therefore there was a risk the practice could not provide emergency treatment to patients suffering from some life threatening medical emergencies.

We saw records showing staff had received training in basic life support and cardio-pulmonary resuscitation (CPR).

The practice had an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Staff were able to easily access it if needed. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance, and were able to access National Institute for Health and Care Excellence (NICE) guidelines via the practice IT system. Staff told us they did not have any documented examples of how they had changed their practice as a result of recent guidance, for example, as a result of national patient safety alerts or by having conducted clinical audits based on NICE guidance.

From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. Patients' needs were reviewed as and when appropriate. For example, we were told that patients with long-term conditions such as COPD (chronic obstructive pulmonary disease) were invited into the practice to have their condition and any medication they had been prescribed reviewed for effectiveness.

Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed. The GPs and practice nurses we spoke with told us there was a process in place for developing specific templates to reflect the needs of the practice and their patients, and ensure that these were in line with NICE guidelines.

Clinical responsibilities were shared between the clinical staff. For example, one of the GPs acted as the medicines lead for the practice. The clinical staff we spoke with were open about asking for and providing colleagues with, advice and support.

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved 99.1% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was 4.6 percentage points above CCG Average and 5.6 above England Average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Patients we spoke with said they felt well supported by the GPs and nursing staff with regards to making choices and decisions about their care and treatment. This was also reflected in most of the comments made by patients who completed Care Quality Commission (CQC) comment cards. Interviews with GPs and the practice nurse demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Discrimination was avoided when making care and treatment decisions. Patients were referred on need and age, sex or race were not taken into account in this decision-making unless there was a specific clinical reason for this.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas such as mental health and prescribing. Other clinical and non-clinical staff had been given responsibilities for carrying out a range of designated roles, including for example, carrying out reviews of the health of patients with a long term condition.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that generally the practice was performing the same as, or better than average, when compared to other practices in England.

The practice had a system in place for completing clinical audit cycles. The practice showed us a sample of four clinical audits undertaken within the last few years. We found that there was insufficient detail included within the clinical audits to determine the standards being monitored. Although some demonstrated the complete audit cycle had taken place, most did not. We found audit was not used effectively to improve quality.

An initial audit on the capacity and success of the practice smoking cessation service was undertaken in January 2015. A further audit was planned in January 2016 to complete the audit cycle. No changes were made as a result of this audit.

Requires improvement

Are services effective?

(for example, treatment is effective)

An initial audit of the use of extra appointments to determine capacity was carried out in May 2015. ('Extra appointments are those booked in addition to normal planned surgeries to ensure patients can be seen in emergencies or if they have a more urgent need.) There was no follow up audit planned. A separate audit was carried out to look at access to the service and capacity in 2013. No changes were made as a result of these audits.

An audit of the outcome of referral to rapid access pain clinics for suspected angina pectoris (Angina is chest pain or discomfort that is caused when heart muscle does not get enough blood). This looked retrospectively at referrals made to the rapid access clinic between June 2014 and December 2014 and the same period in 2013. This audit was to confirm the appropriateness of referrals and did not identify improvements that could be made.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors. The practice achieved 100% of the points available for QOF for the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy.

The practice was good at identifying patients who needed additional support and was proactive in offering this. For example, there was a register of all patients with dementia. Nationally reported QOF data for 2013/14 showed that: 100% of eligible patients with dementia had received a range of specified tests six months before, or after, being placed on the practice's register. (This was 21.9 percentage points above the local Clinical Commissioning Group (CCG) average and 19.8 points above the England average); 88.9% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (This was 4.9 percentage points above CCG Average and 5.1 above the England Average). The practice had a system in place to identify patients who might be at risk of developing dementia. Staff told us this helped to ensure this group of patients received appropriate care and support, and clinicians were aware of their needs.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis.

The practice had care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice. This included care plans for patients with long-term conditions who were most at risk of deteriorating health and whose conditions were less well controlled; for the most elderly and frail patients and those with poor mental health. These patients all had a named GP or clinical lead for their care. We saw examples of these care plans and found them to be detailed and comprehensive. All patients over the age of 75 had been informed who their named GP was and had been given the opportunity to request another doctor if that was their preference.

Nationally reported QOF data for 2013/14 showed the practice had recorded the smoking status of 90.3% of eligible patients aged over 15. The data also showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The percentage of patients aged 15 or over who were recorded as current smokers who had a record of an offer of support and treatment within the preceding 24 months was 91.4%. (This was 6.4 percentage points above the local CCG average and 6.2 points above the England average).

Nationally reported QOF data for 2013/14 showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. The data showed that the records of 81.4% of eligible women, aged between 25 and 65 years of age, contained evidence they had had a cervical screening test in the preceding five years. (This was in line with average at 0.7 percentage points below the local CCG average and 0.5 points below the England average.)

The QOF data also showed 96.0% of eligible women, aged 54 or under, who were prescribed an oral or patch contraceptive method, had received appropriate contraceptive advice during the previous 12 months. (This was 5.2 percentage points above the local CCG average and 6.6 points above the England average.) Overall, the data showed that the practice's performance in providing contraceptive services was 3 percentage points above the

Requires improvement

Are services effective?

(for example, treatment is effective)

local CCG and 5.6 above the England average at 100%. The practice also performed well in relation to the provision of maternity services. Their performance (at 100%) was in line with the local CCG and 0.9% above the England average.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

Staff checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up-to-date with attending mandatory courses such as basic life support. The one area where staff had not undertaken training was infection control.

We saw there was a documented induction process for new employees.

Once a month the practice closed for an afternoon for Protected Learning Time (PLT). A part of this time was dedicated to training. Role specific training was also provided. The practice nurse and healthcare assistant had been trained to administer vaccines. The need for further update training on cervical screening and baby immunisations had been identified as a priority in the last staff appraisal for the practice nurse.

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

Nursing staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, they were trained to administer vaccines and carry out reviews of patients with long-term conditions such as asthma.

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported. Our interviews with staff confirmed the practice was proactive in providing staff with access to appropriate training that was relevant to their role.

Holidays, study leave and sickness were covered in-house wherever this was possible. Although administrative and support staff had clearly defined roles, they were also able to cover tasks for their colleagues in their absence. This helped to ensure the team were able to maintain the needed levels of support services at all times.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet patients' needs.

We saw multi-disciplinary meetings were held. For example, there were palliative care meetings bi-monthly. This meeting was attended by the GPs, practice nurses, administrative leads and the district nurses. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff to pass on, read and action any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for undertaking the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

We spoke with the managers of three local care homes who had residents who were patients from this practice. They all told us the practice responded well to requests for appointments and communications processes between the practice and the homes were effective.

Requires improvement

Are services effective?

(for example, treatment is effective)

Information sharing

An electronic patient record was used by all staff to coordinate, document and manage patients' care. A member of the reception team told us all staff were fully trained in using the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference

Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

Consent to care and treatment

We found that the majority of staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Most clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Decisions about, or on behalf of patients who lacked mental capacity to consent to what was proposed, were made in their best interests and in line with the MCA 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

GPs and the practice nurse we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for the fitting of contraceptive implants and routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Health promotion and prevention

New patients were offered a 'new patient check'. The initial appointment was scheduled with the healthcare assistant, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting areas. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and take action to improve and maintain it.

Other than promoting a healthy life style there was no information on the practice website about health promotion and prevention.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff told us this system worked well and prevented any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. However, the practice performed lower than other practices within the local CCG on rates for a number of child hood vaccinations. For example Mumps, Measles and Rubella (MMR) vaccination rates for five year old children were 78.6% compared to an average of 94.5% in the local CCG area. Infant Men C vaccination rates for two year old children were 81.3% compared to 98.10% across the CCG; and for five year old children were 85.7% compared to 97.9% across the CCG. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was in line with the national average.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients and two family carers patients during our inspection. They were all happy with the care they received. Patients told us they were treated with respect and were positive about the staff. They told us they would recommend the practice to family and friends. Comments left by patients on the eight CQC comment cards we received also reflected this. Six of these were wholly positive commenting on the helpfulness of staff and the good service they received. The two remaining comment cards also commented on the good service they received. However, they also included negative feedback. One commented on a recent experience of poor customer service, which they felt was unusual within the practice.

We found the practice had not taken appropriate steps in some areas to protect the privacy and dignity of patients. Conversations could be overheard in the treatment rooms adjoining the waiting area. There was no music or other sound to muffle this and prevent confidential conversations being overheard. We spoke with the practice manager about this, who said that normally a health information DVD was played in the waiting area to muffle sound. However, the DVD on the television in the waiting area was broken.

However, there were some arrangements in place to ensure the privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wished to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

We saw staff who worked in the reception areas made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in consultation rooms with an appropriate couch for examinations and a privacy screen to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

We looked at data from the National GP Patient Survey, published in January 2015. This demonstrated that patients were mostly satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 95% (compared to 92% nationally) of patients said they had confidence and trust in their GP. Although, only 77% said their GP was good at treating them with care and concern (compared to an average of 83% nationally and 85% across the local CCG area).

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. Many of the comments on the Care Quality Commission (CQC) comment cards referred to the helpful nature of staff. This was reflective of the results from the National GP Survey where 90% of patients felt the reception staff were helpful, compared to a national average of 87%.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients were less satisfied with questions about their involvement in planning and making decisions about their care and treatment. For example, the survey showed 71% of respondents said the GP and 67% said the nurse was good at involving them in decisions about their care. This compared to a national average of 75% and 66% respectively.

81% felt the GP and 76% felt the nurse was good at explaining treatment and results compared to a national average of 82% and 77% respectively.

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

Requires improvement

Are services caring?

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

We saw that access to interpreting services was available to patients, should they require it. They said when a patient requested the use of an interpreter, staff could either book an interpreter to accompany the patient to their appointment or, if it was an immediate need, then a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or those who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice routinely asked patients if they had caring responsibilities. This was then noted on the practice's computer system so it could be taken into consideration by clinical staff.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff were familiar with the individual needs of their patients and the impact of the local socio-economic environment. Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We saw the practice referred people to the local services, where the aim was to help particular groups of patients to improve their health. For example, smoking cessation programmes, and advice on weight and diet.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability, this was noted on the medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Longer appointments were made available for patients who needed them and for those with long-term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey published in January 2015 confirmed this, although performance was slightly lower than for comparators. 82% of patients felt the doctor gave them enough time, with a local Clinical Commissioning Group (CCG) average of 88% and England average of 85%

82% felt they had sufficient time with the nurse, with a local CCG average of 86% and England average of 80%

The practice had a Patient Participation Group (PPG) which was a virtual group with 5 members. We were unable to speak with members of the group as they were unavailable at the time of the inspection. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For example, the practice had published an annual report on the work of the PPG. Following a patient survey they had developed an action plan which was shared with the PPG. This included actions on areas of improvement for the practice. These were:

- To inform patients of waiting time to see GP
- To promote availability of on-line services to improve telephone access to the practice
- To continue to offer additional clinics over lunch hours as well as morning and afternoon surgeries to increase availability of GP appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended on a Monday to provide early morning appointments. Appointments were also available over Thursday and Friday lunchtimes. This helped to improve access for those patients who worked full-time.

Patients were not offered choice in the gender of GP they wished to consult. Both GPs within the practice were male and there were no alternative arrangements available for those patients who wished to see a female GP.

Services had been designed to reflect the needs of the diverse population served by the practice. The practice had access to and made frequent use of translation services, for those patients who did not speak English as a first language.

The premises and services had been adapted to meet the needs of people with disabilities. There was a ramp at the front entrance to allow wheel chair access. All patient facilities were at ground floor level and there was wheelchair and step-free access to all the consultation and treatment rooms. The practice had a portable hearing loop, but was in the process of purchasing a new one to update this facility.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice provided staff with equality and diversity training. Staff we spoke with confirmed that they had completed this training.

Access to the service

Appointments were available on Monday 7:30am to 6pm, Tuesday to Friday 8:30am to 6pm. The practice manager told us that if any patient needed an urgent appointment, GP carried out appointments at the end of surgery to ensure that all patients were seen.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

One patient who filled in a CQC comment card commented that they would like to see more evening appointments to meet the needs of those patients who worked during the day. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent. This was supported by National GP Survey results, where 92% said they were able to see or speak to someone last time they tried, compared to a local CCG and England average of 85%. Also, 99% of patients found the appointment was very or fairly convenient, compared to an average of 93% in the local CCG area and 92% across England.

Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure patients had access to the right care at the right time. The National GP Patient Survey results showed that 79% of patients were satisfied with opening hours, compared to a national average of 76%. Patients rated the ease of getting through to the surgery very highly, with 97% saying they found it easy to get through to someone at the surgery on the phone, compared to a local CCG average of 79%, and an England average of 72%.

The practice website was very basic and did not include some important information to help patients access the service. For example, there was no information provided about how to request home visit appointments or how to make an appointment. The website did refer patients to contact reception to find out how to access on-line services. Information on the out-of-hours service was provided to patients. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice did not have a complaints leaflet or other patient information which set out the process they should follow, and who patients could go to if they needed support in making a complaint. There was also no information available to patients which set out what they could do if they remained unsatisfied with the way their complaint had been handled.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

Of the six patients we spoke with, and the feedback we received from the eight CQC comment cards completed by patients, none raised concerns about the practice's approach to complaints.

We looked at the summary of complaints that had been received in the 12 months prior to our inspection. There were three complaints. We found these had been reviewed as part of the practice's formal annual review of complaints.

Where mistakes had been made, we noted these had been investigated and findings reported back to the patients and taken action to ensure they were not repeated. However, we noted the practice had not formally apologised to patients.

Complaints and lessons to be learned from them were discussed at staff meetings. Changes had been implemented where necessary. For instance, the practice had changed its referral process to Child and Adolescent Mental Health Services as a result of a complaint.

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

We found the practice did not have a formal business plan in place. We found there was a lack of strategic leadership and vision within the practice. Staff were unclear what the strategy and plan were for the practice. Audits had been carried out, but these did not identify and lead to improvements in the quality of the service provided.

However, the lead GP told us they had made improvements as a result of an earlier inspection of another practice they owned. This included the introduction of better documentation to support the practice in carrying out their work. For example, the introduction of common policies and procedures and better documentation of significant events and audits. We spoke with six members of staff and they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

The arrangements for governance and performance management did not always operate effectively. There had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice and in paper copy behind the reception desk. We looked at a sample of these policies and procedures and saw they had been reviewed regularly and were up-to-date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed they were performing above the local Clinical Commissioning Group (CCG) and England averages. Performance in these areas was monitored by the practice manager and GPs and supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical and internal audits, but the results of these audits did not demonstrate outcomes for patients had improved.

We found paper medical records were not securely stored and improvements were required to ensure that medical records were stored in a way that protected patient confidentiality. These were stored in areas accessible by patients and were not locked.

Leadership, openness and transparency

The practice had a clear management structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and GP had leads in areas such as safeguarding and mental health. We spoke with six members of staff and they were all clear about their own roles and responsibilities.

We saw from minutes that staff meetings were held regularly. Staff told us that there was an open culture within the practice and they were actively encouraged to raise any incidents or concerns about the practice. This ensured honesty and transparency was at a high level.

We found the practice leadership had started to introduce processes which would support continuous improvement, but these were at an early stage of development.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff, for example, whistleblowing and safe recruitment policies. These were easily accessible to staff via a shared intranet on any computer within the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, a virtual patient participation group and complaints received.

The practice had a virtual patient participation group (PPG), and gathered feedback and opinion on improvement plans through email correspondence. We tried to contact members of this group on a number of occasions but were unable to get in contact with them.

The practice manager showed us the analysis of the last patient survey they had carried out, which was considered in conjunction with the PPG. The practice published an annual report into the work of the PPG and this was available on the practice website.

Are services well-led?

Requires improvement

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

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT). (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT. There were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place. Staff members had personal development plans. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and these were shared with staff at meetings to ensure the practice improved outcomes for patients. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.

We found that arrangements to learn from incidents and events were in early stages of development and further implementation was required to ensure the practice could demonstrate a proactive and learning culture.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The provider had not ensured that all premises and equipment used by the service were clean, and had not maintained standards of appropriate hygiene for the purposes for which they were being used. Regulation 15 (1) (a) (2).

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 (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not assessed the risk of and had not ensured appropriate arrangements to detect, prevent and control the spread of infections. Regulation 12 (2)(h). The provider had not ensured there was sufficient equipment and medicines available to ensure the safety of patients presenting with a medical emergency. Regulation 12 (2) (f).

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 (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The provider did not have appropriate arrangements in place to ensure the privacy of patients and the security and confidentiality of paper medical records.

This section is primarily information for the provider

Requirement notices

Regulation 10.