Drs Easton, Colgate, Richter & Flowerdew

Quality Report

Orchard Surgery
New Road
Melbourn
Royston
Herts
SG8 6BX
Tel: 01763 260220
Website: www.orchardsurgerymelbourn.co.uk

Date of inspection visit: 04 September 2014
Date of publication: 22/01/2015

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

Contents

Summary of findings

Overall summary

Orchard Surgery provides primary medical services to people living in the village of Melbourn, Hertfordshire and the surrounding areas.

There are approximately 7,500 patients registered at the service with a team of five GP partners. GP partners held managerial and financial responsibility for running the business. In addition there is an additional salaried GP, three registered nurses, three health care assistants, a practice manager, an assistant practice manager, nine administrative staff and six dispensers.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice provides services to a diverse population age group, is situated in a semi-rural location and is a dispensing practice. A dispensing practice is where GPs are allowed to dispense the medicines they prescribe for patients who live remotely from a community pharmacy. Not all patients at the practice are entitled to this service.

Patients told us they feel that the practice is safe. They told us that care is given to them in accordance with their wishes and opportunities are given for informed decision making. Patients told us they feel the practice was responsive to their needs. For example, patients said that an urgent appointment could always be obtained on the day they contact the practice and they could usually see their named GP for non-urgent visits. This reflected the information provided on the practice website.

Patients told us about their experiences of the practice. Their responses were positive from the 20 patients we spoke with on the day, from the six patient participation group members, in the five comment cards left for us and within the practice's own patient survey 2012/13. PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs to achieve high quality and responsive care.

Patients were pleased with the care they received and were very complimentary about the staff at the practice. There were sufficient staff working at the practice. However, the lack of overview on staff training meant that some staff had not had their clinical competency assessed and had missed some training. Medicines were well managed in the practice and within the dispensary and systems were in place to monitor medicines management. The practice was visibly clean and had effective infection control processes in place.

Patients said they felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated, although the process followed was informal and inconsistent. There was no evidence to show that all staff had been informed about the outcome, learning and actions taken following such investigations.

Recruitment, pre-employment checks and induction processes were robust. A new phase of staff appraisals had also been welcomed by staff.

The practice was effective in the way it provided care to patients. Documentation we reviewed about the practice demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

The practice was not always well led or proactive in monitoring the safety and effectiveness of the service provided. Some approaches to significant events, consent and complaints were managed in different ways by the GPs. This lack of systemic standardised approach meant that learning and changes in work patterns were not always shared with the wider staff group. There was insufficient evidence to show that the practice actively sought the views of patients or staff to monitor the effectiveness of the care provided.

Patients were unclear about how they would raise a complaint. Complaints were not managed in a consistent way and the policy did not reflect recognised complaint guidance and contractual obligations for GPs in England.

The staff spoke highly of the management within the practice and told us they felt supported in their roles. However, there was no formalised protected time to share learning and discuss changes to guidelines and protocols.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

The practice had systems to help ensure patient safety and responded to emergencies well.

Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. Risk assessments were present when a decision had been made not to perform a criminal records check using the disclosure and barring (DBS) service on administration staff.

Significant events and incidents were investigated, although the process followed was informal and inconsistent. There was no evidence to show that all staff had been informed about the outcome or that learning and actions had been taken forward following such investigations.

There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were suitable arrangements for the efficient management of medicines, both within the general practice and within the dispensary.

The practice was visibly clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard. There were effective systems in place for the retention and disposal of clinical waste.

Are services effective?

Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the clinical systems at the practice were efficiently run. However, we found that not all GPs were following national guidance regarding the codes used, which affected some data being provided.

Summary of findings

The practice had a clinical audit system in place and audits had been completed. We saw that care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice.

Supporting data obtained both during and after the inspection showed staff employed at the practice had received appropriate support and appraisal. GP partner appraisals had been completed annually. However there were gaps in training, including the annual competency assessment of pharmacy staff.

We saw that the practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

The service was caring. We spoke with patients who spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education.

Patients told us they were included in the decision making process about their care.

Patients told us they felt they had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations, or through any subsequent diagnosis and treatment.

Are services responsive to people's needs?

Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

Patients were not aware of how to make a complaint. The information on the practice website was not clear and timescales meant patients had a restricted time in which to make a complaint. There was a complaints policy available within the practice but this was not always followed. The practice had responded appropriately and in a timely way to any complaints received but did not monitor complaints for trends or patterns.

The evidence we saw did not show that the practice recognised the importance of patient feedback. However, the practice staff were

Summary of findings

beginning to seek patients' views through a new patient participation group. PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs to achieve high quality and responsive care.

Practice staff had identified that not all patient groups found it easy to attend the practice. As a result the practice staff had worked effectively to take the service to the patient. This included the GP and practice nurses visiting two local schools for children with special needs, providing annual health checks for patients with learning disabilities in their own homes and visiting two local traveller communities to provide health care and health screening.

Patients said it was easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent.

Are services well-led?

The service was well led. Nursing staff, GPs and administrative staff demonstrated they were clear about their responsibilities including how and to whom they should escalate any concerns.

Staff spoke positively about their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

There was a clinical auditing system in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred. However, GPs worked in isolation when managing events. There was no clear, systematic system in place to use these to identify, monitor, assess and manage risks to the health, welfare and safety of patients.

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

Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they preferred. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people. Vaccines for older people who had problems getting to the practice or those in local care homes were administered in the community by the practice nurses. Nurses and doctors undertook home visits for older people and for patients who required a visit following discharge from hospital.

Clinics specifically for older people were not held at the practice, but treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery care. This included a community matron for the elderly in the community. The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

The practice worked to avoid unnecessary admissions to hospital and worked jointly with other health care professionals to provide a streamlined care service. The GPs had direct access to a consultant geriatrician for advice on the best treatment and support for older patients. The GPs were also involved in an acute geriatric intervention service. This is a joint community service with the ambulance service where GPs, community staff and the local ambulance service visited the patient at home to assess the best course of treatment for the individual concerned. This sometimes helped to avoid patients being admitted to hospital, where this was most appropriate for the patient.

The dispensary provided medicines in blister packs for older people with memory problems and delivered these to the patient.

People with long-term conditions

The practice identified patients who might be vulnerable, including those with multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. The staff at the practice maintained links with external health care professionals for advice and guidance. Patients with long term conditions had tailor-made care plans in place. Particular clinics operated for patients with diabetes, heart failure, hypertension, high

cholesterol, renal failure, asthma and chronic respiratory conditions. The nurses attended educational updates to make sure their lead role knowledge and skills were up to date. Practice staff also involved healthcare specialists for advice where appropriate.

The practice had clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients. There was a blood pressure machine in the waiting area so patients could monitor their own blood pressure. There was a weight management clinic for patients to attend and referrals to dieticians were made where appropriate.

There were monthly diabetic clinics to treat and support patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

Home visits and medicine reviews were provided for patients with long term conditions who had been recently discharged from hospital.

Patients receiving certain medicines were able to access screening services at the practice to make sure the medicine they received was effective.

The practice computerised patient record system could be accessed by out of hours service providers if the patient had given permission for this to happen. GPs and out of hours doctors were then aware of any treatment that had been given to people with long term conditions or those at the end of their life.

Mothers, babies, children and young people

Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available, including practice nurses visiting local travellers, to ensure babies and children could access a full range of vaccinations and health screening.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics at the practice. The midwives had access to the practice computer system and could speak with a GP should the need arise. The practice had effective relationships

with health visitors and the school nursing team, and were able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice referred patients and worked closely with a local family and child service who attended the monthly multidisciplinary team meetings to discuss any vulnerable babies, children or families.

Women had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. There were quiet private areas in the practice for women to use when breastfeeding.

A GP had been the named GP for two special needs schools in the area and clinical staff had been trained to take blood from children to avoid them having to go to hospital.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

The working-age population and those recently retired

Patients who were of working age or who had recently retired were pleased with the care and treatment they received.

The percentage of working age and recently retired patients was significantly higher than the national average. Advance appointments (up to six weeks in advance) and evening appointments were available once a week to assist patients not able to access appointments due to their working hours. There was an online appointment booking system, which patients said was useful. Six patients said it would be beneficial to include practice nursing appointments on this system. The practice staff were informed of this and stated they would consider this. The practice also used a text message reminder service for some patients.

There was a newly set up virtual patient participation group at the practice which had a high number of working age members. The group had been recently set up. Members said they had been asked to give feedback for the CQC inspection and understood this was a new process.

Suitable travel vaccine advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available within the waiting areas.

Summary of findings

The staff carried out opportunistic health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicine reviews. The practice also offered age appropriate screening tests including prostate and cholesterol testing.

Patients who received repeat medicines were able to collect their prescription at a place of their choice. Dispensary staff posted the prescription to a pharmacy of the patient's choice, which may be convenient to their work place.

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

The practice had a vulnerable patient register. These patients were reviewed monthly at the multidisciplinary team meetings.

Staff told us that few patients had a first language that was not English. Patients with interpretation requirements were known to the practice. Family members were used to translate with the patients' consent. The practice staff knew they could access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment. The practice website had an ability to translate text about the services on offer.

Patients with learning disabilities had received a health check within the last year, during which their short and long term care plans were discussed with the patient and their carer if appropriate. The staff at the practice visited these patients in their own home, to reduce stress and improve communication.

The practice provided health care for two local traveller communities, whereby practice staff were invited to visit patients in their homes to offer health education, screening and immunisation programmes.

Practice staff were able to refer patients with alcohol addictions to an alcohol service for support and treatment. The support service visited the practice if the patient chose this.

The practice used a community matron who visited any vulnerable patients to assess and facilitate any equipment, mobility or medicine needs they may have.

Summary of findings

People experiencing poor mental health

A GP had been appointed as a lead for mental health patients. A register at the practice identified patients who had mental illness or mental health problems.

Patients had access to a counsellor provided by the practice and were offered ongoing support by the counsellor and GPs. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

In house mental health medicine reviews were conducted to ensure that patients' medicines remained appropriate and that the dose was still correct. Blood tests were regularly performed on patients receiving certain mental health medicines.

There was communication, referral and liaison with a psychiatry specialist who offered advice and support and an outreach clinic was available in a nearby town. This community based service was run by the local clinical commissioning group, Hertfordshire CCG. The GPs could refer patients for mental health assessment and also treatment for older patients who had mental health issues. This included advice and assessments for patients with dementia.

Staff were aware of the Mental Capacity Act 2005 but had not received training on this. There were nationally recognised examination tools used for people who were displaying signs of dementia.

Summary of findings

What people who use the service say

We spoke with 20 patients during our inspection. We also received six emails from representatives of the virtual patient participation group (PPG). PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs to achieve high quality and responsive care.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected five comment cards which contained detailed positive comments.

Comment cards stated that patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Comments also highlighted a confidence in the advice and medical knowledge and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients and emails from the PPG members. The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they got good treatment. Patients told us that the GPs were excellent.

Not all patients knew how to complain but told us they mostly had no complaints.

The main issue for patients was getting through on the telephone first thing in the morning. However, patients were pleased with the choice of appointments when they did get through.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and liked the online appointment booking appointment system. Four patients commented that they would like to be able to book practice nurse appointments on line. This practice staff said this could be considered. Patients said they thought the website was good and was developing.

None of the patients we spoke with had been asked for their feedback, either through a survey or via the PPG. The PPG group said the group had just been set up.

Areas for improvement

Action the service MUST take to improve

The practice must have suitable arrangements in place ensure that dispensary staff received appropriate assessment of competency and training updates. The staff training programme must be monitored effectively to ensure staff can demonstrate they were competent in their roles and were aware of where to find and have access to guidelines and protocols.

The practice must bring the complaints system to the attention of service users and those acting on their behalf and provide support and assistance where necessary. The practice must review the complaints policy to ensure that accountability for complaints investigation is clear. The practice should review the timescales within the policy to ensure they reflect recognised guidance and contractual obligations for GPs in England.

Significant events, incidents and complaints must be managed and analysed in a systematic way to identify, monitor, assess and manage risks to the quality, health, welfare and safety of patients, and make sure learning is shared across the whole practice team.

Action the service SHOULD take to improve

The practice should be more active in seeking the views of patients.

Summary of findings

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice are proactive in their outreach towards vulnerable groups or patients who may find it difficult to access primary care. For example:

- The GP and practice nurses visited two local schools for children with special needs in order to provide care in a familiar environment. The practice has ensured that staff have the skills they need to support vulnerable patients appropriately. For example, a nurse had received additional training in taking blood from children to reduce the need for children to go to hospital for blood tests.
- Patients with learning disabilities were visited in their own homes by the GP and practice nurse for their annual health check. This reduced stress and improved communication with patients.
- The practice provided primary health care to two local traveller communities, enabling practice staff to visit patients in their own homes to offer health education, screening and immunisation programmes.
- Practice nurses also visited vulnerable older people in their own homes and those in care homes to offer vaccinations.

Drs Easton, Colgate, Richter & Flowerdew

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a second CQC inspector, a GP specialist advisor, a practice manager specialist advisor, and an expert by experience. An expert by experience is a person who has experience of using care services. They are part of the inspection team and spend time talking to patients to gain their views and experiences at the practice.

Background to Drs Easton, Colgate, Richter & Flowerdew

Orchard Surgery provides primary medical services to people living in the village of Melbourn, Hertfordshire and the surrounding areas.

At the time of our inspection there were approximately 7,500 patients registered at the practice with a team of six GPs meeting patients' needs. Five of these GPs were partners and one was a salaried GP. In addition there were three registered nurses, three health care assistants, a practice manager, an assistant practice manager, nine administrative staff and six dispensers.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice provides services to a diverse population age group, is in a semi-rural location and is a dispensing practice. A dispensing practice is where GPs are allowed to dispense the medicines they prescribe for patients who live remotely from a community pharmacy. Not all patients at the practice were entitled to this service.

Orchard Surgery is open between Monday and Friday: 08.30am – 6.00pm with evening appointments available each Wednesday. These are pre-bookable appointments designed to be used by patients going to work.

Outside of these hours a service is provided by another health care provider (Urgent Care Cambridgeshire) by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

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

How we carried out this inspection

Before conducting our announced inspection of Orchard Surgery, we reviewed a range of information we held about

the practice and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before or during the inspection.

We carried out our announced visit on Thursday 4 September 2014. We spoke with 20 patients and 11 staff at the practice during our inspection and collected five patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, the strategic business manager, five GPs receptionists/clerical staff, practice nurses, and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients. We also received emails from six of the 10 representatives from the patient participation group (PPG). PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs to achieve high quality and responsive care.

We looked at documentation that related to the management of the surgery and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

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

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

Are services safe?

Our findings

Safe Track Record

The GPs each managed their own events in isolation but there was no evidence of systematic process or monitoring events as a practice. Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the doctors undertook a Significant Event Analysis (SEA) to establish the details of the incident and the full circumstances surrounding it.

Learning and improvement from safety incidents

At Orchard Surgery the process following a significant event was not formal or standardised throughout the practice. This lack of a systematic approach meant that it was difficult to establish whether learning points and actions were known and adopted by the practice as a whole instead of just by individual GPs for the purposes of their revalidation process. The lack of systemic approach also meant that there was insufficient evidence to show that any changes following a SEA were embedded in everyday practice. There was no evidence to show that facilitated team-based meetings were held on a regular basis to discuss, investigate and analyse events.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children. They had been trained to the appropriate advanced level. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them.

There were monthly multidisciplinary team meetings with relevant attached health professionals including, social workers, district nurses, palliative care, physiotherapist and occupational therapists where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings.

Staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or 'at risk' child had been seen by different health professionals, these staff had access to the computer system and were made aware of the patients' circumstances. The staff told us they had received safeguarding training, which training records confirmed. They told us they were aware of who the safeguarding leads were and demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. The practice website described that patients were entitled to have a chaperone present for any consultation, examination or procedure where they felt one was required.

The practice had a written policy and guidance for providing a chaperone for patients which included expectations of how staff are to provide assistance. Health care assistants at the practice acted as chaperones as required. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate. Posters were displayed informing patients of the chaperone service.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Monitoring Safety & Responding to Risk

Are services safe?

Reception and clerical staff had instructions around how to manage a telephone call when a patient says they are calling with an emergency. Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

Medicines Management

The GPs were responsible for prescribing medicines at the practice. The practice was a dispensing practice. A dispensing practice is where GPs are allowed to dispense the medicines they prescribe for patients who live remotely from a community pharmacy. Not all patients at the practice were entitled to this service. Dispensing staff had clear systems which identified patients who were entitled to use this system.

The dispensary was managed by six members of staff. There were clear standard operating procedures explaining how to manage issues such as medicine errors, waste management and dispensing processes.

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been seen and signed by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

Patients explained they could collect their medicines from a place of their choice even if they were a dispensing patient. There were clear systems to ensure these requests were followed.

Medicines in the dispensary were stored safely. Medicines were supplied to the dispensary in secured delivery boxes and records kept of these stock checks.

The dispensary was alarmed secure and was not accessible to members of the general public. The dispensary areas were clean and free from a build-up of excess stock. Hand washing facilities, aprons and gloves were available for staff to use.

We spoke with dispensing staff who told us they reported any medicine errors and that these were minimal.

The dispensing staff had received training in medicine management and dispensing to a level appropriate to their role. Staff had access to detailed standard operating procedures for guidance which had been recently reviewed.

We checked the controlled drugs storage and management and found these to be appropriate. Controlled drugs are types of medicine which required additional storage and record keeping. There was a clear audit trail of receipt and issue of controlled drugs. The practice had clear procedures in place for the disposal of controlled drugs.

Other medicines stored on site were also managed well. There were effective systems in place for the obtaining using, safekeeping, storing and supply of medicines. Clear checks and temperature records were kept to strengthen the audit of medicines issued and improve medicine management.

All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. A cold chain is a temperature-controlled supply chain. An unbroken cold chain is an uninterrupted series of storage and distribution activities which maintain a given temperature range. It is used to help extend and ensure the shelf life of medicines. We looked at the storage facilities for refrigerated medicines and immunisations. The staff were seeking to ensure the vaccine fridges are hard wired to ensure a continual supply of power.

Patients were informed of the reason for any medicine prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

Are services safe?

Systems were in place so that checks took place to ensure products were kept within expiry dates. Those medicines which required refrigeration were stored in secure fridges. Fridge temperatures were monitored daily to ensure that medicines remained effective.

Staff were clear about the responsibility for checking medicines in the GP on call bag. The bag was stored in the dispensary. Medicine levels and expiry dates were monitored by dispensary staff.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received five completed cards. Of these, three specifically commented on the building being clean and tidy. Patients told us staff used gloves and aprons and washed their hands.

The practice had policies and procedures on infection control and these had been recently reviewed. We spoke with the infection control lead, who was the lead nurse. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nurse and health care assistants described the steps they took in between patient appointments, such as changing gloves, hand-washing, changing bed roll, and wiping the couch, to reduce risks of cross infection.

Infection control audits were undertaken monthly and improvements made where necessary. For example wall mounted hand dispensers had been purchased and fitted to provide more space in treatment rooms. The staff training record showed that staff had received updated training in infection control.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out by external contract cleaners. A system was in place to raise issues with contractors.

Clinical waste and sharps were being disposed of in safe manner. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. The practice did not use locums as staff covered for each other during staff absence.

Criminal records checks were only performed for GPs and nursing staff, not clerical and administrative staff. Clear recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check..

The practice had clear disciplinary procedures to follow should the need arise.

The registered nurses' Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Dealing with Emergencies

The practice had a suitable business continuity plan that documented the practice's response to any prolonged period of events that may compromise patient safety. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work. Staff knew where to find this and were also provided with flow charts for guidance.

The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service.

There was a duty system in operation to ensure one of the nominated GP partners covered for their colleagues, for example emergency home visits and checking blood test results.

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had been included on the basic life support training sessions.

Equipment

The emergency medicines and equipment available, together with the arrangements in place ensured they were serviced or safe to use. Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Are services safe?

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in February 2014.

Staff told us they had sufficient equipment at the practice. There were a small number of mercury blood pressure machines (sphygmomanometer) present at the practice. European Union guidance suggests these are phased out. The practice were aware of this and made sure they had mercury spillage kits available in case mercury was spilt.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Clinical Excellence (NICE) guidance and we saw that where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used The Quality and Outcome Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice varied. Some outcomes showed they generally achieved high or very high scores in areas that reflected the effectiveness of care provided. However, we found that not all GPs were using the same codes, which affected the data being provided. The practice manager was informed of this and said this would be addressed. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area with the exception of two areas which reflected the data entry issues.

Management, monitoring and improving outcomes for people

The practice provided a service to up to 7,500 patients. The practice were keen to ensure that staff had the skills to meet patients' needs. For example, one of the nurses had been trained to take blood from children in local special needs schools to prevent avoidable hospital visits.

The GPs referred patients to a virtual hospital. This is a resource where up to 10 patients are cared for in their own homes by the local community based services. This enabled patients to remain at home and to be treated for a short period of time avoiding a hospital admission where appropriate.

Doctors in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes.

Nursing staff told us they considered the practice was continually trying to improve outcomes for patients. For example, It had been was identified that longer appointment times were needed for when the patients attended for their first shingles immunisation in order to obtain a detailed patient history.

Effective Staffing, equipment and facilities

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The three GPs we spoke with told us these appraisals had been appropriately completed.

Nursing and administration staff had received an annual formal appraisal and kept up to date with their continuous professional development programme. We saw documented evidence to confirm that this process was robust.

The practice manager had identified that clerical, administration and dispensary staff had not been receiving regular formal appraisal prior to their appointment. This had been recently actioned by making sure that all staff had been given an appraisal. A system to monitor this had been introduced.

There was a comprehensive induction process for new staff.

The staff training programme was not monitored effectively. For example none of the seven staff files we looked at contained evidence of fire safety training or fire drills to show they knew how to respond to fires in an emergency. Staff told us they had attended a drill but not the formal fire training. Four dispensary staff files we looked at did not contain an annual assessment of competency to show they were competent in their role. There was no formal protected time for continuous professional development for the clinical team. This meant there was not a time set aside to discuss significant events, complaints or to review guidelines and protocols to ensure their knowledge was up to date.

Staff training records showed that all staff were up to date with training including basic life support and infection control. Staff said that they could ask to attend any relevant external training to further their development.

Are services effective?

(for example, treatment is effective)

There was a set of policies and procedures for staff to use. However, these were in paper format and located within the practice manager's office. Not all staff were aware of where these were stored or where to find guidance or policies on the computer system.

Working with other services

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, school nurses, district nurses, community matrons and the mental health team.

Communication with the out of hours service was effective as the out of hours doctors were able to access patient records, with their consent. Patients discharged from hospital were seen at home by their GP for a medicine review. The GPs told us there was sometimes a delay in receiving paper discharge letters from hospital but that this was due to improve with the introduction of electronic discharge letters. Patients told us they had been advised by the hospital to see by their GP following discharge from hospital.

The practice worked effectively with other services. Examples given were alcohol services, parenting support groups, specialist nurses and mental health outreach clinics.

Health Promotion & Prevention

There were regular clinics for patients with complex illnesses and diseases. A full range of screening tests were offered for diseases such as prostate cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such as weight management, alcohol management and smoking cessation clinics.

Patients were able to monitor their own blood pressure by using the automated machine in the waiting room.

The nursing staff explained that when patients were seen, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel vaccination advice, long term conditions and minor illnesses. These links were simple to locate.

Family planning, contraception and sexual health screening was provided at the practice.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and particularly appreciated that GPs came to the waiting room to greet their patients.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We received five completed cards which contained detailed positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Cards commented on patients' confidence in the advice from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the ongoing care arranged by practice staff.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and always conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Health care assistants at the practice act as chaperones as required. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback from the

comment cards showed that patients had different treatment options discussed with them, together with the positive or possible negative effects the treatment may have.

There was a lack of consistency in how staff recorded consent at the practice. Staff used different ways to record when patients gave consent including electronic records, paper records and free text included in the patients' general notes. We saw evidence of patient consent for procedures including immunisations, injections, ear syringing and minor surgery.

Patients told us that nothing was undertaken without their agreement or consent at the practice. The number of patients with a first language other than English was very low. The practice staff knew they could access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act 2005 to make decisions in the patient's best interest.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice was all on one level and so provided easy access to all. Chairs in the waiting room had been changed to include some with arm rests to assist patients to stand. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. The reception staff assisted and supported patients who required it appropriately.

Patients we spoke with told us they felt the practice was responsive to their individual needs. They told us that they had been visited at home when appropriate and they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were usually made by the GP who was most familiar with the patient.

The practice was responsive to patient needs. For example, practice nurses and a GP had made a decision to visit certain vulnerable patients in their own homes. This included vaccinations for the elderly, annual health checks for patients with learning disabilities, primary health care for a local community of gypsies and travellers and attending two local special needs schools.

There had been a new patient participation group (PPG) set up. PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs to achieve high quality and responsive care.Members of this group were keen to become involved at the practice but said they had not yet been consulted about issues.

Access to the service

Patients were able to access the service in a way that was convenient for them.

A 2012/2013 survey performed by the practice showed that 55% of the 79 respondents were able to see a GP on the same day or next day and 70% were able to see a GP on the same day if their need was urgent. 55% of the respondents were able to either always or almost always see a GP of their choice.

These findings were reflected during our conversations. Patients were happy with getting an appointment. They liked the on line booking system and suggested that access to practice nurse appointments were managed this way. We fed this back to the practice manager who said this would be considered.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity but said this meant there was sometimes a delay in seeing the GP of their choice.

The main criticism from patients about appointments was getting through on the telephone at 8.30am in the morning. They said this was not only time intensive, but also was an extra financial cost because of the automated reply.

Information about the appointment system was found on the practice website, front door and by reception desk. Patients were aware of the out of hours arrangements when the practice was closed by a poster displayed in the practice, on the website and on the telephone answering message.

The practice offered a text reminder service to all patients if they wished and this was encouraged for patients who may be more likely to forget or miss their appointment. A patient who used this service said it was very useful.

Meeting people's needs

Systems were in place to ensure any referrals, including urgent referrals for secondary care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them and arranged in a timely way.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other. Patients said their test results had been either given immediately, phoned through by a GP, sent by letter or supplied when they phoned the practice. Everyone was certain that there was no delay, no matter which method was used.

We received a comment card from a patient who had registered as a temporary resident. The comments referred to a high quality treatment and kind, understanding and helpful staff.

Concerns & Complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice did not have a clear system in place for handling complaints and concerns.

Not all patients were aware of how to make a complaint but said they felt confident that any issues would be managed well.

The practice website stated that patients who wished to complain should contact the practice to speak with an appropriate person. There were no clear instructions around who the complainant should contact.

The complaints policy at the practice stated that complaints may be made up to three months after an incident. After this time it was at the discretion of the practice manager whether to deal with the complaint or not. The practice policy stated that the complaints would be handled and investigated by the practice manager and be responded to within three months. However, we saw that the practice manager did not always handle and investigate all complaints at practice. The example of a complaint we saw showed the response had been sent within three months but had been investigated and managed by a GP and notes kept by the GP. This did not show that complaints were managed in a coordinated way.

Staff were not clear who was responsible for handling complaints at the practice. Staff said they would refer any problems to the person's GP.

The policy stated that a record must be kept of each complaint and reviewed at practice meetings to ensure that learning points are shared. However, we were not provided with evidence to show this had occurred. Records of complaints were held by each GP rather than centrally so trends and patterns could not be monitored.

Are services well-led?

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

Our findings

Leadership & Culture

Staff spoke positively about the practice and of their employment. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. All of the staff we spoke with had worked at the practice for many years and were positive about the open culture within the practice.

There was a visible leadership presence at the practice and a sense of compassion, dignity and equality for patients demonstrated by staff.

Nursing staff said they were supported to communicate informally through meetings and formal staff appraisal. However, we did not see any records of nursing or clinical meetings.

Governance Arrangements

The systems in operation to manage governance of the practice were informal. Staff were unclear who the lead for governance was at the practice.

The GPs had formal partners meetings every month. Minutes of these were kept and showed that clinical issues, incidents and complaints were not discussed at these meetings.

Although significant events, incidents and complaints were managed as they occurred there was no clear system in place to use these to identify, assess and manage risks to the health, welfare and safety of patients. The GPs met informally on a daily basis and said this was a time when they discussed clinical issues and complaints as they arose. There were records of staff meetings up until November 2013 but none since this time. There was no evidence provided to show team-wide discussion and shared learning had taken place following significant events analysis (SEA), clinical issues or complaints.

Staff said that matters were dealt with as they arose. There was no evidence of scheduled nursing, clinical or management meetings taking place. This meant that opportunities to discuss matters that may have an impact on patient care and safety may be missed.

Complaints were managed by individual GPs. There was no recognised systematic approach for sharing learning from complaints outcomes.

Systems to monitor and improve quality & improvement (leadership)

The quality of care was reflected in the practice achievements against the Quality and Outcomes Framework (QOF) which compared well to other practices in the clinical commissioning group. It was noted that there was lack of consistency in how some data was re-coded. This meant that the results were not always accurate to use.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. These examples included medicine audits, audits on unscheduled hospital admissions and the use of emergency contraception. Audits were thorough and followed a complete audit cycle.

Patient Experience & Involvement

A survey had been conducted in 2012/2013 by the practice. 79 of the 7,500 had responded. The findings were positive.

Patients we spoke with had not been asked for their views about the practice. The website offered patients the opportunity to give feedback if they chose. We were informed of a change to seating in the waiting area. We were informed that patients had not been consulted or asked about this before the change was introduced. This may show that the practice was not as active as they could be to obtain feedback from patients.

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

Staff told us they had informal opportunities to feedback ideas or concerns but there were no formal meetings where this could happen.

The practice has a virtual patient participation group (PPG), which had been set up earlier in the year. PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs to achieve high quality and responsive care. The PPG members who responded said their first correspondence was a request to offer feedback for the CQC inspection.

Are services well-led?

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

None of the patients we spoke with were aware of the PPG. However, information was clearly displayed on the patient TV in the waiting room and on the practice website.

Management lead through learning & improvement

There was a lack of standardised, formal, systematic processes followed to ensure that learning and improvement take place. There was no formal protected time set aside for continuous professional development for the clinical team. This meant there was not a time set aside to discuss significant events, complaints or to review guidelines and protocols. The format and process following significant events and complaints was not formal or standardised throughout the practice. This lack of a systematic approach meant that it was difficult to establish whether learning points and actions were known and adopted by the practice as a whole.

Identification & Management of Risk

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. For examples risk, COSHH and health and safety assessments of the building.

Older people

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

Our findings

Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they preferred. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people. Vaccines for older people who had problems getting to the practice or those in local care homes were administered in the community by the practice nurses. Nurses and doctors undertook home visits for older people and for patients who required a visit following discharge from hospital.

Clinics specifically for older people were not held at the practice, but treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery care. This included a community matron for the elderly in the community. The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

The practice worked to avoid unnecessary admissions to hospital and worked jointly with other health care professionals to provide a streamlined care service. The GPs had direct access to a consultant geriatrician for advice on the best treatment and support for older patients. The GPs were also involved in an acute geriatric intervention service. This is a joint community service with the ambulance service where GPs, community staff and the local ambulance service visited the patient at home to assess the best course of treatment for the individual concerned. This sometimes helped to avoid patients being admitted to hospital, where this was most appropriate for the patient.

The dispensary provided medicines in blister packs for older people with memory problems and delivered these to the patient.

People with long term conditions

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

Our findings

Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they preferred. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people. Vaccines for older people who had problems getting to the practice or those in local care homes were administered in the community by the practice nurses. Nurses and doctors undertook home visits for older people and for patients who required a visit following discharge from hospital.

Clinics specifically for older people were not held at the practice, but treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery care. This included a community matron for the elderly in the community. The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

The practice worked to avoid unnecessary admissions to hospital and worked jointly with other health care professionals to provide a streamlined care service. The GPs had direct access to a consultant geriatrician for advice on the best treatment and support for older patients. The GPs were also involved in an acute geriatric intervention service. This is a joint community service with the ambulance service where GPs, community staff and the local ambulance service visited the patient at home to assess the best course of treatment for the individual concerned. This sometimes helped to avoid patients being admitted to hospital, where this was most appropriate for the patient.

The dispensary provided medicines in blister packs for older people with memory problems and delivered these to the patient.

Mothers, babies, children and young people

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

Our findings

Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available, including practice nurses visiting local travellers, to ensure babies and children could access a full range of vaccinations and health screening.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics at the practice. The midwives had access to the practice computer system and could speak with a GP should the need arise. The practice had effective relationships with health visitors and the school nursing team, and were able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice referred patients and worked closely with a local family and child service who attended the monthly multidisciplinary team meetings to discuss any vulnerable babies, children or families.

Women had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. There were quiet private areas in the practice for women to use when breastfeeding.

A GP had been the named GP for two special needs schools in the area and clinical staff had been trained to take blood from children to avoid them having to go to hospital.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Working age people (and those recently retired)

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

Our findings

Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available, including practice nurses visiting local travellers, to ensure babies and children could access a full range of vaccinations and health screening.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics at the practice. The midwives had access to the practice computer system and could speak with a GP should the need arise. The practice had effective relationships with health visitors and the school nursing team, and were able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice referred patients and worked closely with a local family and child service who attended the monthly multidisciplinary team meetings to discuss any vulnerable babies, children or families.

Women had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. There were quiet private areas in the practice for women to use when breastfeeding.

A GP had been the named GP for two special needs schools in the area and clinical staff had been trained to take blood from children to avoid them having to go to hospital.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

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

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

Our findings

The practice had a vulnerable patient register. These patients were reviewed monthly at the multidisciplinary team meetings.

Staff told us that few patients had a first language that was not English. Patients with interpretation requirements were known to the practice. Family members were used to translate with the patients' consent. The practice staff knew they could access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment. The practice website had an ability to translate text about the services on offer.

Patients with learning disabilities had received a health check within the last year, during which their short and long term care plans were discussed with the patient and their carer if appropriate. The staff at the practice visited these patients in their own home, to reduce stress and improve communication.

The practice provided health care for two local traveller communities, whereby practice staff were invited to visit patients in their homes to offer health education, screening and immunisation programmes.

Practice staff were able to refer patients with alcohol addictions to an alcohol service for support and treatment. The support service visited the practice if the patient chose this.

The practice used a community matron who visited any vulnerable patients to assess and facilitate any equipment, mobility or medicine needs they may have.

People experiencing poor mental health

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

Our findings

A GP had been appointed as a lead for mental health patients. A register at the practice identified patients who had mental illness or mental health problems.

Patients had access to a counsellor provided by the practice and were offered ongoing support by the counsellor and GPs. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

In house mental health medicine reviews were conducted to ensure that patients' medicines remained appropriate and that the dose was still correct. Blood tests were regularly performed on patients receiving certain mental health medicines.

There was communication, referral and liaison with a psychiatry specialist who offered advice and support and an outreach clinic was available in a nearby town. This community based service was run by the local clinical commissioning group, Hertfordshire CCG. The GPs could refer patients for mental health assessment and also treatment for older patients who had mental health issues. This included advice and assessments for patients with dementia.

Staff were aware of the Mental Capacity Act 2005 but had not received training on this. There were nationally recognised examination tools used for people who were displaying signs of dementia.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered Person did not have suitable arrangements in place ensure that dispensary staff receive appropriate assessment of competency or training updates. The staff training programme was not monitored effectively to ensure staff can demonstrate they were competent in their roles and were aware of where to find and have access to guidelines and protocols. Regulation 23 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: The practice did not effectively bring the complaints system to the attention of service users and those acting on their behalf and provide support and assistance where necessary. The practice did not review the complaints policy to ensure that accountability for complaints investigation is clear. The practice had not reviewed the timescales within the policy to ensure they reflected recognised guidance and contractual obligations for GPs in England. 19 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

How the regulation is not being met:

The registered person did not identify, assess and manage risks or use the complaints or analysis of incidents to regularly assess and monitor the quality of service provided.

There was no evidence to show that significant events, incidents and complaints are managed in a systematic and standard way to identify, assess and manage risks to the health, welfare and safety of patients and show learning had taken place with the whole team.

Regulation 10 (1) (2)

>