Wimbledon Village Surgery

Quality Report

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Date of inspection visit: 14 May 2014
Date of publication: 04/11/2014

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.

Summary of findings

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Summary of findings

Overall summary

Wimbledon Village Surgery is on the High Street in Wimbledon Village. The practice has a patient list size of approximately 10,000 people. It is open Monday to Friday from 8.30am to 6.30pm and offers appointments until 8pm two evenings (Mondays and Thursdays). Patients can have telephone consultations and a home visit if needed. All GPs have personal patient lists to ensure continuity of care for patients and to better meet their needs. Health visitors are attached to the service and provide clinics on-site.

The practice is in purpose-built premises and is set out over two floors. There are seven consulting rooms, two treatment rooms, a meeting room and a staff room as well as a reception area. The practice is an NHS general practice and is registered to carry out the regulated activities of diagnostic and screening procedures, family planning services, maternity and midwifery services, treatment of disease, disorder and injury and surgical procedures.

Overall we found the practice was providing a responsive, well-led, effective and caring service. However, there were some areas that required improvements to ensure it was safe at all times. The practice employed two nurses and could not demonstrate their child protection competencies by means of producing certificates confirming completion of level 2 child protection training. Recruitment processes did not ensure that all staff were of suitable character, as not all personnel files included photographic identification, references were not checked for one member of staff and they had not assessed the risk appropriately for non-clinical staff not having a Disclosure and Barring Services (DBS) check carried out. The practice told us they had assessed the risk of non-clinical staff not having DBS check as being a low risk. However, they provided no clear rationale for this assessment and we saw no documentation to confirm that this had been assessed formally.

All the patients we spoke with during the inspection were complimentary about the service. Patients felt the service was good and responsive to their needs. They described staff as caring and hardworking and valued the service.

We saw positive outcomes for patients experiencing mental health problems. Prescribing for medication was low and medication was monitored effectively to control mental health conditions. There were regular reviews for patients with long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD), asthma and high blood pressure and the practice had good links with other organisations involved in managing long term conditions. The practice worked closely with a local hospice providing end of life care and local care homes, and it held regular meetings with district nurses and psychiatric services. Effective processes were in place to ensure babies and children received appropriate immunisations and staff followed up where there were gaps in immunisation records. Older people valued the service and told us that staff were caring and responded to their needs appropriately.

Although governance arrangements were in place, they were not always formally documented. The practice supported its staff and in the files we looked at, we saw evidence of clinical staff completing sufficient hours for their continuing professional development.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were required to ensure the practice provided a safe service at all times. Equipment and medicines were maintained and stored properly and recorded. Staff knew how to handle a medical emergency. Accidents and incidents were reported appropriately internally, but the provider was not aware of requirements to report incidents to the regulator in line with the Health and Social Care Act 2008. The practice could not evidence that the nurses had level 2 child protection competencies in line with intercollegiate guidance. The practice did not record numbers on hand written prescription pads to make sure they were all accounted for. Although some staff knew what to do in an emergency or major incident, there were no formalised arrangements in place. This meant there were no assurances of business continuity in the absence of those who did know.

Are services effective?

Overall the practice was effective. The service demonstrated that it followed national guidance in assessing patients' needs and delivering care and treatment. We saw good examples of positive outcomes for patients who use the service. Generally staff were supported to carry out their roles effectively. However the practice could not demonstrate that the nurses had level 2 child protection competencies.

Are services caring?

The practice was caring. We observed staff interacting positively with patients. Staff were polite, caring and respectful towards patients. All the patients we spoke with during the inspection were very pleased with the way staff treated them. Patients told us they felt involved in decisions about their care and the GPs gave examples of interactions with patients to support this.

Are services responsive to people's needs?

Overall the practice was responsive to the needs of patients. The GPs in the practice had separate patient lists which enabled them to be responsive to each person's needs and facilitate continuity of care. There was an effective complaints system in place and the practice learned from patients' feedback. However, the complaints policy was not readily available for patients.

Summary of findings

Are services well-led?

Overall the practice was well-led. There was an open and transparent culture with clear divisions of roles and responsibilities. Clinical staff were able to explain their areas of responsibility and lead roles to us. Staff were confident to approach the management and told us managers responded to their needs well.

Staff told us the Patient Participation Group (PPG) was active. We attempted to contact members of the PPG but did not receive any feedback from members, so were unable to confirm what staff had told us. GPs involved patients in their appraisal reviews.

Although governance structures existed, they were not always formalised in written procedures or plans. For example, there was no written business continuity plan. Furthermore not all staff knew whether the practice had a business continuity plan.

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
Overall the practice responded to the needs of older people well. The surgery has a higher than average number of patients from this population group.

People with long-term conditions
Overall the practice responded well to the needs of this population group.

Mothers, babies, children and young people
Overall the practice responded well to the needs of mothers, babies, children and young people.

The working-age population and those recently retired
Overall the practice responded well to the needs of the working age population and recently retired.

People in vulnerable circumstances who may have poor access to primary care
Overall the practice responded well to the needs of this population group.

People experiencing poor mental health
Overall the practice responded well to the needs of people in this population group.

Summary of findings

What people who use the service say

We spoke with eight patients and received 14 completed comment cards. Patients were generally very positive about the practice. Patients felt that having a dedicated GP was good. They felt safe knowing their GP knew about their health and they did not have to keep explaining their medical history. This was particularly useful for people with long term conditions who saw their GP regularly.

Most patients we spoke with said that it was not difficult to get appointments. The majority told us they could always get a same-day appointment for urgent matters and non-urgent appointments were usually available within two days. A few patients commented that there was sometimes limited choice in getting a booked appointment for the time or date requested.

Patients told us that staff were very friendly and approachable. We observed that staff knew some patients by name and were polite and courteous. Some of the patients we spoke with commented that the GPs collect them from the waiting room when it was their turn to be seen. This added a caring touch, which patients appreciated.

Areas for improvement

Action the service MUST take to improve

- The provider must ensure that it has effective systems to make all checks required to ensure the suitability of staff employed in the service are in line with Schedule 3 of the Health and Social Care Act 2008. This includes being able to demonstrate they have appropriately assessed the risks associated with not carrying out criminal record checks through the Disclosure and Barring Services (DBS) for non-clinical staff.

Action the service COULD take to improve

- The nurses in the practice had not completed level 2 child protection training in accordance with the intercollegiate guidance published by The Royal College of Paediatrics and Child Health (RCPCH). The provider needs to ensure that they can demonstrate staff competencies at the recommended professional levels.
- The practice does not have a written business continuity plan. A formalised plan will ensure that all staff working in the practice are clear on the risk management procedures and react appropriately in the event of an incident.
- The practice does not currently monitor the use of hand written prescription pads and therefore cannot respond to stolen or lost hand written prescription pads. There should be a system in place to manage this risk.

Good practice

Our inspection team highlighted the following areas of good practice:

- The practice had a protocol for joint prescribing with the hospice. This ensured patients received a service that was streamlined to ensure the service was delivered effectively.

Wimbledon Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC Inspector. The inspector was accompanied by three specialist advisers (a GP, a practice manager and a pharmacist inspector). The specialist advisers were issued with warrant letters to certify that they were authorised by the Care Quality Commission to enter and inspect the premises in accordance with sections 62 and 63 of the Health and Social Care Act 2008.

Background to Wimbledon Village Surgery

Wimbledon Village Surgery is on the High Street in Wimbledon Village. The practice has a patient list size of approximately 10,000 people. It is open Monday to Friday from 8.30am to 6.30pm and offers appointments until 8pm two evenings (Mondays and Thursdays). Patients can have telephone consultations and a home visit if needed. All GPs have personal patient lists to ensure continuity of care for patients and to better meet their needs. Health visitors are attached to the service and provide clinics on-site.

The area has a high proportion of older people, which is reflected in the number of older people registered at the practice. Most of these people have lived in the area most of their lives and have been patients with the practice for many years.

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

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before the inspection we analysed information about the practice from CQC's Intelligent Monitoring and from other

Detailed findings

sources including the local clinical commissioning group (CCG), Office for National Statistics, Public Health England and results from the GP National Survey. We also spoke with NHS England, the CCG and Healthwatch Merton.

The inspection team spent nine hours inspecting the service. This time was spent talking to a range of staff including GPs, practice nurses, the practice manager, reception staff and administration staff. We also spent time talking to patients about their experiences of the practice. We reviewed policies and procedures, which included looking at audits, complaints handling and health and safety checks (fire risk assessments and infection control procedures). We also observed interactions between staff and patients (outside of consultations).

Are services safe?

Summary of findings

Equipment and medicines were maintained and stored properly and recorded. Staff knew how to handle a medical emergency. However, overall, the practice needed to make some improvements to ensure it provided a safe service at all times. Accidents and incidents were reported appropriately internally, but the provider was not aware of requirements to report incidents to the regulator in line with the Health and Social Care Act 2008. The practice could not demonstrate that the nurses had level 2 child protection competencies in line with intercollegiate guidance. The practice did not record numbers on hand written prescription pads to make sure they were all accounted for. Although some staff knew what to do in an emergency or major incident, there were no formalised arrangements in place. This meant there were no assurances of business continuity in the absence of those who did know.

Our findings

Safe patient care

The practice had arrangements in place to provide safe care and to monitor risks. Incidents were reported and investigated, medicines and the risks associated with them were appropriately managed and patients were protected from the risk of infection.

The Health and Social Care Act 2008 requires providers to report certain incidents to the regulator. Regulation 18 outlines the incidents providers are required to report to the regulator. The provider told us they were unaware of the requirement and therefore had not been reporting incidents in line with the requirements. They assured us they would put processes in place to rectify this, and begin sending notifications in line with requirements.

Learning from incidents

The practice maintained a record of all significant events. There was an effective system in place to review incidents and learn from them to prevent or minimise the chance of them re-occurring. Meetings were held every three to four months to discuss and review significant events. Staff we spoke with were aware of the reporting processes for significant events and confirmed they were updated with lessons learned following incidents.

Safeguarding

The practice had safeguarding policies and procedures in place. One of the GPs was the assigned safeguarding lead for the practice and was accredited by the National Society for the Prevention of Cruelty to Children (NSPCC). The practice was involved in multi-disciplinary meetings relating to safeguarding and child protection. There were monthly meetings with staff and safeguarding was a fixed agenda item. This included making staff aware of their roles and responsibilities for safeguarding.

All the GPs had completed level 3 child protection training and safeguarding of vulnerable adults training. It was unclear what level of child protection training the nurses had achieved. The provider was unable to demonstrate their competency level by means of producing certificates or any other evidence confirming level 2 competencies (in line with professional guidance). The practice manager showed us evidence that the nurses were due to receive level 1 training. However, this was still not in line with intercollegiate guidance for safeguarding children and

young people, which suggests that nurses should be trained to a minimum of level 2. The practice manager gave us assurances that they would also be booked to receive formal training at level 2.

Monitoring safety and responding to risk

The practice had processes in place to respond to risks. All staff had been trained in handling medical emergencies and were prepared to act in a potential situation. There were appropriate drugs and equipment to deal with medical emergencies, including a defibrillator and anaphylactic drugs for adults and children. We looked at the emergency drug kit and all items were in date. Staff confirmed that the equipment and drugs were checked regularly to ensure the equipment was working properly and they kept records of these checks. We spoke with three non-clinical staff about responding to medical emergencies and they were all aware of what to do in a medical emergency.

Medicines management

Vaccines and other medicines were stored in fridges with a thermometer that recorded the temperature. On the day of our visit the fridge temperatures were within the required temperatures of 2 and 8 degrees Celsius. We saw evidence that the fridge temperatures were checked daily and documented.

We saw reliable systems in place for prescriptions and repeat prescriptions to minimise errors and promote the safety of patients. Patients could request prescriptions by email or fax. Non-clinical staff could re-authorise repeat prescriptions, but these were always checked by a GP. Prescriptions were marked with an "r" when re-authorised by non-clinical staff to indicate that they needed to be checked by a GP. Non-clinical staff also monitored whether repeat requests were made too frequently to avoid patients requesting more than required. The patients we spoke with confirmed that they usually received repeat prescriptions within 48 hours.

According to the repeat prescribing policy, the practice manager was responsible for managing the orders for the repeat prescriptions and vaccines. To keep track of prescription orders the practice kept a log of when the pharmacist collected and received prescriptions. If GPs made a home visit they would use a hand-written prescription. All hand-written prescription pads were stored in a locked cupboard. However, the practice did not keep a record of hand-written prescription pad numbers, therefore there was no way of knowing which GP took which hand written prescription pad or if a blank hand-written prescription had been taken without being authorised.

Cleanliness and infection control

We saw appropriate procedures in place to reduce the risk and spread of infection. The practice had a written infection control policy (which covered waste disposal and hand hygiene) for all staff to refer to. There were appropriate arrangements for the safe disposal of clinical waste. Clinical waste bins were in all the consulting rooms and were not filled above the stipulated levels. The treatment rooms were clean and tidy and had appropriate hand washing facilities. The practice was cleaned daily by an external company and records were maintained of the daily cleaning tasks. Certain areas of the practice were deep cleaned every two months. This included the chairs in reception, doors and toilets. The practice manager told us that the carpets were due to be renewed soon. On the day of our visit the practice was clean and tidy. All the patients we spoke with said the practice was always presentable when they visited.

Staffing and recruitment

All clinical staff had Disclosure and Barring Service (DBS) checks. The practice manager told us there was currently no system in place for non-clinical staff to have DBS checks. We were told they had looked into it and assessed that non-clinical staff did not pose much of a risk. However, this was not a formal assessment of the risk and the practice did not provide documentation to confirm they had carried out the risk assessment. We were told that the requirement for non-clinical staff to have a DBS check was something that had been raised with the partners in the practice and was being explored for the future.

The practice had no written recruitment policy and we found gaps in checks (required under schedule 3 of the Health and Social Care Act 2008) for some staff before they began work. We reviewed the files of three non-clinical members of staff. One file had no curriculum vitae (CV) and no written internal or external references had been checked. We were told that a verbal reference had been provided for this member of staff. However, there was no record of a verbal reference being taken. Two out of the three files that we looked at for non-clinical members of staff did not have photo identification on file.

Are services safe?

The practice responded appropriately to risks relating to staffing levels. We looked at the staffing rota and the practice manager explained that it was drawn up to ensure there were always sufficient members of staff to respond to actual and potential risks. Non-clinical staff were trained to cover each other's duties so could perform "multiple duties" and step in if someone was absent. For example, all non-clinical staff were trained to cover reception.

Dealing with emergencies

We noted that the practice did not have a written business continuity plan for dealing with incidents or emergencies that would disrupt patient care, which meant staff had no procedures or processes to refer to. The senior partners gave a comprehensive explanation of what they would do in an emergency. Other members of staff told us they were unsure whether there was a business continuity plan or what formal arrangements existed. For example, two of the GPs we spoke with said they were unsure if there was a written plan and one of them stated that if there was they had not seen it.

Equipment

Clinical equipment was safe and effective for use. The practice had a defibrillator and oxygen for use in a medical emergency and records showed these were checked regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the practice was effective. The service demonstrated that it followed national guidance in assessing patients' needs and delivering care and treatment. We saw good examples of positive outcomes for patients who use the service. Generally staff were supported to carry out their roles effectively. However the practice could not demonstrate that the nurses had level 2 child protection competencies.

Our findings

Promoting best practice

When we spoke with clinical staff in the practice many of them referred to guidance they used such as National Institute for Health and Care Excellence (NICE) guidelines and the Mental Capacity Act 2005.

We saw examples of when GPs had provided care using evidence-based assessments. For example, we were told about a case where a consultant from the hospital had recommended a particular course of medication for a patient. The GP at the practice queried this recommendation and requested the results from the hospital. They reviewed the evidence using current guidance, which indicated that medication was not required.

Management, monitoring and improving outcomes for people

The practice demonstrated that it identified and monitored issues well to improve outcomes for patients. Clinical audits were used to review care and treatment, assess the quality of the service and identify areas for improvement.

We looked at a clinical audit completed in February 2014 to evaluate the diagnosis of uncomplicated urinary tract infections to assess if antibiotic prescribing was in line with Public Health England guidance. We saw that the aims and method of the audit were outlined, and actions were set. The results of the audit were discussed at a multi-disciplinary meeting and appropriate actions were taken to improve outcomes for patients.

Although the practice nurses saw diabetic patients for routine reviews, neither of them were trained specifically in diabetes or asthma, so they could only do observation monitoring. If a patient's medication needed to be changed, they would have to see one of the GPs. This meant that patients would potentially have to re-visit the surgery if they attended for a review appointment. The practice worked closely with the community diabetes liaison outreach team. GPs could refer patients to the team, which included diabetic specialist nurses and dieticians, to improve the management of their conditions. Diabetic patients were monitored by staff at the practice and the liaison team so there was a joint approach to monitoring this long term condition.

Are services effective?

(for example, treatment is effective)

The practice used the NHS choices choose and book service for most referrals. In some cases GPs would make direct referrals to specialists. There was an effective system in place to monitor and control non-attendance to referred appointments. Patients were contacted to find out why they had not attended. Staff were able to monitor reasons for non-attendance to try to minimise this for the future.

The practice had good arrangements for patients with mental health problems. General Practice Outcomes Standards (GPOS) data highlighted that anti-depressant prescribing was very low compared to the national average. GPs told us this was because medication was not the first choice of treatment to manage psychiatric illnesses. GPs told us that patients generally preferred to access private therapeutic or counselling services as opposed to taking medication, but they also referred patients to the local NHS-funded counselling services. The practice had good links with the consultant psychiatrist who attends the surgery with a community psychiatric nurse (CPN) monthly to discuss current and potential issues with patients within the practice. We saw notes from these meetings and saw they led to positive outcomes for patients.

The practice monitored patients who were prescribed certain medication, including Lithium. Patients on Lithium had regular blood testing every three months and checks were carried out before any new medication was prescribed to ensure it was safe and appropriate. Patients were given NHS lithium cards with information about the medication they were taking.

Staffing

There were informal processes in place for the induction of new staff and on-going development for existing staff. The practice manager explained the recruitment process for staff who had recently been employed. We spoke with the new staff and they confirmed they had received an informal induction and had either completed relevant training or it was planned. Staff were supported in one-to-one and other informal meetings.

All the GPs we spoke with said that they had completed appraisals and had been revalidated. Revalidation is the process by which licenced doctors have to demonstrate that their knowledge is up to date and they are fit to practise. One of the GPs showed us a personal development plan that had been agreed following an appraisal. They had found this useful because it helped them to identify areas where training was required, for example, it identified that they needed to update their safeguarding training.

The practice manager explained that clinical staff attended training and information sharing sessions to keep their knowledge up to date. For example, nurses had completed training sessions to enhance their knowledge of cancer care, diabetes and high blood pressure. However, the provider was unable to demonstrate the nurses' child protection competency levels by means of producing certificates or any other evidence confirming they had level 2 competencies in line with professional guidance.

Senior staff demonstrated that they managed staff performance issues in line with the practice's policy.

Working with other services

There were processes in place to work closely with other organisations and professionals. For example, district nurses provided support and care to some of the older people registered with the practice and the practice had good relations with the local hospice. The GPs met regularly with district nurses to plan effective care for those patients at the end of their life. They also had a protocol for joint prescribing with the hospice to ensure the service was delivered effectively.

The practice received appropriate information about its patients from the out-of-hours service and information was triaged appropriately. The IT system was automatically updated and information updated a patient's file if they had seen the out-of-hours service the night before. GPs would review the information the next morning and take the appropriate action if needed.

Health, promotion and prevention

The practice had systems in place to promote healthy living and prevent disease for existing patients, but did not carry health checks for new patients. All new patients who had an existing long-term condition were asked to see a GP before they were prescribed any repeat medication.

Nurses ran one-to-one smoking cessation sessions with patients. The practice manager explained that these were preferred rather than clinics because clinics were restrictive and tied patients to a specific date and time. The individual sessions allowed flexibility for patients and a more person-centred service. The practice had a poor record of reporting the smoking status of patients, which staff told us

Are services effective?

(for example, treatment is effective)

was due to a backlog of notes that needed to be summarised. However, we saw that efforts were being made to improve this. Staff were prioritising all new patients' records first as a way to pick up new cases and additional staff had been taken on, who were dealing with the backlog. In addition, a form had been devised for existing patients to complete when they attend for routine appointments so their smoking and drinking status could be updated and recorded.

Are services caring?

Summary of findings

The practice was caring. We observed staff interacting positively with patients. Staff were polite, caring and respectful towards patients. All the patients we spoke with during the inspection were very pleased with the way staff treated them. Patients told us they felt involved in decisions about their care and the GPs gave examples of interactions with patients to support this.

Our findings

Respect, dignity, compassion and empathy

We observed many interactions between staff and patients during our visit. Staff were very caring and respectful towards patients and each other. The practice had a high proportion of older patients and we saw that staff referred to many of them by their first name. The interactions were respectful and caring. The GPs had individual patient lists. This allowed them to develop a good understanding of their patients' medical history and health care needs so patients could be confident in the GPs that treated them. The practice had an automated system to display a patient's name when it was their turn to see a GP. However, most GPs walked to the reception to collect their patients. We spoke with eight patients during our visit and most of them commented that they appreciated the GPs coming to collect them. This was particularly important to older patients who used the service. When staff entered consulting rooms we observed that they always knocked before entering to ensure they did not interrupt a consultation.

The practice had a chaperone policy in place. Posters in the reception area advised patients of their rights to have a chaperone if they wished. Most patients we spoke with were aware of the policy. One patient we spoke with told us that they had been offered a chaperone previously when they required an examination. None of the non-clinical staff had received chaperone training, but one of the GPs told us that these staff would never be used as a chaperone, as it would always only be another GP or a nurse.

The practice provided support to patients to cope with bereavement. There were notices in the reception to inform patients about counselling services and bereavement support. Two of the GPs we spoke with explained that because they had personal lists, GPs would make contact with patients directly if they knew they were bereaved or were experiencing personal difficulties.

Involvement in decisions and consent

Patients told us they were involved in decisions about their care and treatment. We spoke to a patient with a long-term medical condition, who said they were very involved in planning their care and treatment and they made informed

Are services caring?

decisions. For example, if their medication was being reviewed the GP always explained why and explained potential side effects and they set timescales for them to come back to test the effectiveness of the changes.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the practice was responsive to the needs of patients. The GPs in the practice had separate patient lists which enabled them to be responsive to each person's needs and facilitate continuity of care. There was an effective complaints system in place and the practice learned from patients' feedback. However, the complaints policy was not readily available for patients.

Our findings

Responding to and meeting people's needs

The practice worked with various organisations to ensure a coordinated approach to the care of patients. A high number of older people were registered as patients. Many patients within this population group were prescribed warfarin. There was a system to enable patients to make an appointment with a practice nurse to take international normalisation ratio (INR) readings to measure how well their warfarin medication was working.

The practice had close links with a local hospice. The practice lead for end of life care worked closely with the district nursing team and the hospice, and held monthly meetings to discuss end of life planning for patients. There were agreed shared protocols in place with the hospice, which staff told us worked well to meet patients' needs.

Access to the service

The practice was open Monday to Friday from 8am to 6.30pm, and was also open until 8pm for appointments two days a week (Mondays and Thursdays). These arrangements were particularly useful for the working age population, who could make appointments around work commitments. Although the doors to the surgery closed for an hour during the day, patients had access to the practice by telephone. GPs were available for patients to speak with during this time if required. The appointments system included the option for patients to book a same-day emergency appointment, telephone consultations and home visits if required. We spoke with patients about these arrangements and most were satisfied with access arrangements and the ability to get an appointment.

A high proportion of patients were older people who had mobility difficulties or other issues that made it difficult to travel to the practice. The GPs at the practice responded to patients' needs and carried out a high proportion of home visits to reflect the needs of their patient population.

Referrals were made through the choose and book system, and patients told us they found this system effective. Urgent referrals were faxed direct and followed up by staff. Non-urgent referrals were booked electronically and patients we spoke with said they found access to these services satisfactory.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns and complaints

The practice had a complaints policy and a notice in the reception area told patients how they could complain. During our visit we asked to see a copy of the policy, but staff did not have one readily available. When we asked how patients were given written information about complaints staff said they did not receive a high volume (of complaints) and they handled each case individually. They acknowledged that if a patient needed a written copy of the complaints procedure, this would not be readily available. The practice told us they would ensure copies were available to patients in the future.

All non-clinical complaints were handled by the practice manager, who demonstrated a good understanding of the complaints procedure and that complaints were handled in accordance with the practice's policy. The practice manager gave an example of how the service had been improved following a complaint made by a patient. The outcome resulted in positive improvements to the service.

Are services well-led?

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

Summary of findings

Overall the practice was well-led. There was an open and transparent culture with clear divisions of roles and responsibilities. Clinical staff were able to explain their areas of responsibility and lead roles to us. Staff were confident to approach the management and told us managers responded to their needs well.

Staff told us the Patient Participation Group (PPG) was active. We attempted to contact members of the PPG but did not receive any feedback from members, so were unable to confirm what staff had told us. GPs involved patients in their appraisal reviews. Although governance structures existed, they were not always formalised in written procedures or plans. For example, there was no written business continuity plan. Furthermore not all staff knew whether the practice had a business continuity plan.

Our findings

Leadership and culture

From our observations we saw an open and honest culture among staff. Staff told us they felt supported and we saw training and development plans which supported this. Staff had access to appropriate development opportunities and there was a clear sense of pride in staff who worked in the practice.

Governance arrangements

The practice had effective governance arrangements in place, although they were not always formalised in written documents. Roles and responsibilities were clearly defined for those with leadership responsibility. There were three partners in the practice and staff were clear about the management structures. The practice did not have a formalised business continuity plan. We spoke with two of the senior partners and they were able to explain what they would do in the event of a major incident. For example, when their IT system went down they were still able to access patient records. Other members of staff we spoke with were unsure whether there was a business continuity plan or what formal arrangements existed. This meant there was no assurance of business continuity in the absence of those who were aware of the informal plan.

Systems to monitor and improve quality and improvement

All the GPs in the practice attended a daily half hour meeting where they discussed issues relating to the practice, quality, serious incidents and quality assurance. Concerns relating to staff performance were also picked up and discussed during these meetings to ensure that actions were put in place to set up appropriate support or take relevant action. It was clear that this meeting formed a significant part of the governance arrangements to ensure the practice was well-led. In addition to this the partners also met every six weeks.

Hand-written prescription pads were kept in a secure locked cabinet. However, the practice had no system in place to record when GPs used the hand-written prescriptions or to record how many they used. This meant there would be no way to audit if hand written prescriptions were being taken or used without authorisation.

Are services well-led?

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

Patient experience and involvement

Staff told us they had an active Patient Participation Group (PPG) and we were told they were consulted on issues or proposed changes in the practice. We were given contact details for members of the PPG but when we contacted these patients from their details, we only received one response. This patient stated that they were unaware they were a PPG member. They told us that they were unable to comment on PPG meetings because they had never attended a meeting. The patient confirmed that generally they had not been involved in decisions made in the practice although they had made some suggestions about improvements to the practice manager.

GPs included patient feedback as part of their appraisals and they used this feedback to plan their development. For example, one of the GPs gave a positive example of how patient feedback led to them changing arrangements for their telephone consultation arrangements.

Staff engagement and involvement

The management were keen for all staff to be aware and involved in developments in the practice. Staff meetings were held every four to six weeks. Staff we spoke with told us they found them useful. If staff were absent they were required to read and sign the minutes to show that they had been updated about issues.

Learning and improvement

All staff in the practice had access to learning and development opportunities. All the GPs and nurses were given five days study leave every year and completed annual appraisals which supported their development. One of the GPs we spoke with explained how they derived a learning plan from their appraisal. The nurses' appraisals were conducted by the partners in the practice and general supervision was monitored by the practice manager. The practice manager co-ordinated learning and development for non-clinical staff and most training was planned on an individual basis. We reviewed staff records and saw that appropriate learning and development opportunities were available to staff. However, the practice could not demonstrate the nurses' child protection level competencies by means of producing a certificate for level 2 training (as recommended by professional guidance) or any other evidence confirming the level they had achieved.

Identification and management of risk

The practice maintained a record of all significant events within the practice. This was to ensure that they learned from the events and could improve on things before they went wrong.

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.

Summary of findings

Overall the practice responded to the needs of older people well. The surgery has a higher than average number of patients from this population group.

Our findings

There were two GPs with lead responsibility for patients aged over 75 years. The practice wrote to all these patients to tell them who the named GPs were and their contact details if they needed to get in touch with them. The practice had good links with local care homes and made home visits regularly to older patients living in the community. GPs had individual patient lists, which was important to this population group. Patients we spoke with said they found it an excellent service to be able to see the same GP. They commented that staff were always respectful and treated them with dignity.

We found that staff were responsive to the needs of patients in this population group and demonstrated a good understanding of their needs. We observed interactions between reception staff and patients and these were all positive. The practice worked well with other organisations to ensure care was delivered effectively and in line with people's needs.

Services for the over 75s' included annual flu jabs and biennial pneumonia jabs. A high proportion of older patients were prescribed warfarin and the practice had very good systems in place to monitor these patients. Patients were able to come to the practice at any time for INR blood testing and did not have to wait for a specific clinic day.

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).

Summary of findings

Overall the practice responded well to the needs of this population group.

Our findings

The practice maintained lists of all patients with chronic long term conditions such as diabetes, asthma, high blood pressure and COPD. This enabled them to easily identify when they needed to review the patient's condition. The practice contacted patients and asked them to make an appointment with a GP to assess whether their medication was effective or to review it if required. All new patients with long-term conditions had to see a GP before any repeat prescribing was authorised.

According to the GPOS framework the practice had lower than average levels for identifying people with diabetes and other long term conditions. The practice had processes in place for the management of long term conditions. For example, staff worked closely with the diabetic liaison team to ensure a joint approach to managing the conditions. Overall we found that the practice had processes in place to support and provide effective treatment to this group.

Annual flu jabs were offered to all patients with chronic long term conditions, and biennial pneumonia jabs were offered.

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.

Summary of findings

Overall the practice responded well to the needs of mothers, babies, children and young people.

Our findings

One of the GPs in the practice had lead responsibility for children and young people. Their website had details about when immunisations were due and which ones should be given. It detailed immunisations that were required from birth up to age 19. This ensured that parents were aware of what immunisations their child required. GPs and health visitors were available to parents to discuss any concerns they may have about the immunisation. Health visitors also provided child care advice and monitored child development. Clinics were held every other week at the practice where parents could book one-to-one sessions for their child.

There was a system in place to identify when a child had received an immunisation and when they had missed one. If a child had missed an immunisation the practice contacted the parent by telephone or in writing and asked them to contact the practice to make an appointment. The health visitors also monitored and picked up on this and would work with the practice to follow up where a child had not had the required immunisations.

Annual flu jabs were available for pregnant women and children.

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.

Summary of findings

Overall the practice responded well to the needs of people from working age population and recently retired.

Our findings

Opening hours were considerate of those working because there were extended evening appointments available two days a week (Mondays and Thursdays). This gave the working age population flexibility in appointments available to them. The people we spoke with in this population group were happy with the service provided to them.

Patients of working age were offered NHS health checks for early screening to pick up early signs of potential long-term conditions such as diabetes. Patients we spoke with said they had received health checks and felt they were valuable to maintaining their health.

Smoking status was recorded for patients (although the practice had a back log of records to summarise so not all patients smoking status was up to date). Details were taken from new patients to record their smoking status. There was an advert promoting smoking cessation in the practice leaflet. Nurses ran one-to-one smoking cessation sessions for patients. Patients found these more effective than clinics because they could be scheduled to fit in with a person's needs and at a time that suited them.

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).

Summary of findings

Overall the practice responded well to the needs of this population group.

Our findings

There was a very low number of patients with a learning disability registered at the practice. The practice had effective systems in place to meet the needs of this group. When a new patient with a learning disability registered they were seen by a GP and then reviewed three months after. If no other conditions required monitoring then they were reviewed annually. Information was available in easy read format so that information was accessible to patients.

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.

Summary of findings

Overall the practice responded well to the needs of people in this population group. The practice demonstrated that they had good systems in place to monitor therapy for people in this group.

Our findings

The practice had a GP with lead responsibility for this group. The GPs had mechanisms in place to monitor and treat people experiencing poor mental health. Anti-depressant prescribing was low. The GPs told us that patients in the practice were more likely to access private counselling and psychological services than to take medication. GPs met with consultant psychiatrists every two months (and CPNs attended occasionally). They discussed all patients currently being seen and those who may potentially be referred. This showed that the practice worked with others to ensure treatment was streamlined.

Lithium therapy monitoring for people with mental health problems was also effective. Patients who were prescribed Lithium had regular blood testing, every three months and checks were carried out before any new medication was prescribed to ensure they were safe. Patients were given NHS lithium cards with information about the medication.

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
Treatment of disease, disorder or injury	Regulation 21 (b) HSCA (Regulated Activities) Regulation 2010 Requirements Relating to Workers The provider failed to ensure that effective systems were in place to carry out all required checks for the suitability of staff employed in the service. The provider failed to ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information is appropriate. Schedule 3 includes the following; proof of identity including a recent photograph, a full employment history, together with a satisfactory written explanation of any gaps in employment, a criminal records certificate or enhanced criminal record certificate.