Dr Paul Unyolo (Talke Pits Clinic)

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Paul Unyolo (Talke Pits Clinic) on 9 February 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be inadequate for providing well-led services, requiring improvement for providing safe and effective services. It also required improvement for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It was good for providing a caring and responsive service.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients were not always kept safe as the arrangements in place for recording, investigating and learning from risks to safety were not robust. The practice was not recording and reviewing significant events effectively which could result in a lack of learning from significant events, and compromise safety.
- The practice was not always managing communications relating to the care and treatment of patients effectively.
- Data showed patient outcomes were at or below average for the locality. Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.

The areas where the provider must make improvements are:

Summary of findings

- Ensure that the recording, investigation and dissemination of significant events is robust.
- Ensure that risks that may affect patient safety are acted upon to minimise the risk of harm to patients.
- Ensure that the processing of communications relating to the care and treatment of patients is robust.
- Ensure that risks to patients and staff from infection are minimised by completing, recording and acting upon findings from regular infection control audits.
- Ensure that records relating to the management and coordination of patient care and treatment are accurately kept.
- Support all staff at the practice with a mechanism to provide individual feedback such as an appraisal and the opportunity to explore individual training needs.

In addition the provider should:

- Expand the process of audit to demonstrate improvement in delivering patient care and treatment; this should also include minor surgery undertaken at the practice.
- Ensure that patients, visitors and staff are protected from the risk of water borne infection by means of completing a legionella risk assessment.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than four months after the initial rating is confirmed. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, investigations were not always documented or followed through.

We saw that risks were not well managed to ensure that patients were being kept safe. An example was the lack of action following an infection control audit that highlighted an issue of concern as the immunity of clinical staff to blood borne viruses was not known. The audit had identified this as a risk, however four months after the audit appropriate action had not been taken to minimise the risk identified.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements must be made.

We saw that the management of communications from other organisations involved in the care and treatment of patients at the practice was not effective. We reviewed computerised communications and saw that some had not been viewed by a GP and any necessary action had not been taken in a timely way. For example, a request from a hospital consultant to arrange an x-ray for a patient had not been actioned for a number of weeks. This had resulted in a delay for the patient receiving the test recommended. A delay in reviewing or actioning health information could have serious consequences for a patient's care or treatment.

Data showed patient outcomes were at or below average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE). We saw one completed audit completed at the practice within that demonstrated a positive effect for patients with a diagnosis of dementia.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence the practice responded quickly to issues raised.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a written vision and a strategy, although all staff displayed a vision and value consistent with an emphasis on caring for patients. There was a documented leadership structure and most staff felt supported by management. The practice had a number of policies and procedures to govern activity, but they were not always followed.

We did not see any clear examples of discussion of governance at meetings. We reviewed minutes of clinical meetings that contradicted themselves and did not contain an accurate record of discussion of issues at that time. The practice had proactively sought feedback from patients and had an active patient participation group (PPG).

All staff had received inductions but not all staff had received regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All of these patients had a named GP and a structured annual review to check that their health and medication needs were met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that showed children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were

Summary of findings

suitable for children and babies. The practice held a joint clinic with a health visitor to review the health of recently born children. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Requires improvement

The practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities and 77% of patients in this group had received a follow-up. The practice offered longer appointments for patients with learning disabilities and also allowed them to walk into the practice to be seen without an appointment.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

We saw that the practice had taken steps to improve the service provided patients experiencing poor mental health. Sixty-three per cent of patients on the practice register for poor mental health had received an annual physical health check. This result had improved from the result of the previous year of 25%.

The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had completed additional training on how to promote care for people with dementia.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. They all described practice staff as caring, helpful and approachable. Patients also told us that they were treated with dignity, compassion and were involved in decisions about their care and treatment.

We collected 44 cards from a comments box left in the practice waiting room for two weeks before our visit. The majority of the comments received were highly positive about the experience of being a patient or carer of a patient registered at the practice. Thirty seven individual comment cards mentioned highly positive themes and words to describe the staff and service at the practice. Four of the comment cards were received were not as positive. Three cards expressed difficulty in obtaining an appointment and one expressed that they had not been contacted by the practice regarding an abnormal test result.

Data from the latest GP national survey published in January 2015 showed 84% of practice patients surveyed rated their overall experience of the practice as good or above. Also 98% of respondents had trust in the last GP they saw or spoke with.

The practice had undertaken its own patient survey in June 2014. The survey was a sample of opinions from 98 registered patients selected at random by the patient participation group (PPG) members. The results of this survey were positive. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We saw that 92% of patients surveyed felt that their concerns are listened to and taken seriously. Also 92% of patients questioned were happy with the time practice staff spent understanding their concerns.

Areas for improvement

Action the service MUST take to improve

Ensure that the recording, investigation and dissemination of significant events is robust.

Ensure that risks that may affect patient safety are acted upon to minimise the risk of harm to patients.

Ensure that the processing of communications relating to the care and treatment of patients is robust.

Ensure that risks to patients and staff from infection are minimised by completing, recording and acting upon findings from regular infection control audits.

Ensure that activities relating to the management and coordination of patient care and treatment are accurately kept.

Support all staff at the practice with a mechanism to provide individual feedback such as an appraisal and the opportunity to explore individual training needs

Action the service SHOULD take to improve

Expand the process of audit to demonstrate improvement in delivering patient care and treatment; this should also include minor surgery undertaken at the practice.

Ensure that patients, visitors and staff are protected from the risk of water borne infection by means of completing a legionella risk assessment.

Dr Paul Unyolo (Talke Pits Clinic)

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a GP and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Dr Paul Unyolo (Talke Pits Clinic)

Talke Pits Clinic is situated in the village of Talke Pits in the borough of Newcastle-Under-Lyme, Staffordshire.

The practice serves a population with historic roots to an industry of coal mining. The practice prevalence of 3.4% of patients with chronic obstructive pulmonary disease (COPD) is nearly double the clinical commissioning group (CCG) average of 1.9%. COPD is a collective term to describe a number of diseases which affect a person's lung function.

Patients of all ages are registered at the practice. There are currently just over 3600 patients being cared for.

There are three GPs (one male and two female) working at the practice. The all-female nursing team of three staff members consists of a nurse practitioner, a practice nurse and a health care assistant. A practice manager, assistant practice manager, a team of five reception and administrative staff undertake the day to day management and running of practice duties.

The practice holds a General Medical Services contract with NHS England and has expanded its contracted obligations to provide enhanced services to patients.

The practice does not provide out-of-hours services to the patients registered there. These services are provided by Staffordshire Doctors Urgent Care Limited.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 February 2015. During our visit we spoke with a range of staff including two GPs, a nurse practitioner, a practice nurse, a healthcare assistant the practice manager,

Detailed findings

assistant practice manager and three members of reception and clerical staff. The inspection team also spoke with a professional therapist from an organisation for people with poor mental health, who was based in the practice but not employed by them. We also spoke with nine patients who used the service. We observed how people were cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The system used for recording, investigation and discussion of significant events at the practice had weaknesses which meant that incidents involving patient safety were not always reviewed to minimise the risk of them reoccurring in the future. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We saw records of three incidents from the previous year that had been reported as significant events. All three had been initially recorded in a logical and thorough structure. However each of the incident reports missed key items of information. For example, the detail of investigations was not clearly recorded. One example was an incident concerning a patient that had died unexpectedly. The practice had recorded this as a significant event. We saw that part of the investigation into the circumstances had not been followed up. This included the medical findings report from HM coroner which had been awaited for four months.

We reviewed safety records, incident reports and available minutes where these were discussed for the previous year. The practice was not able to supply minutes to cover all meetings held. A GP told us that minutes were not always taken and he recognised that there was a weakness in the system used. The practice was not able to evidence that issues had been discussed and followed up. A GP told us that significant events were discussed at clinical meetings that were held every eight weeks. We reviewed two sets of available minutes taken at clinical meetings during the previous year. There was evidence in one set of minutes that incidents had been discussed, however actions taken or required were not clear. We did not see any evidence of the three recorded significant events being discussed at a meeting. Although there was evidence within the reporting process records to suggest some discussion, reflection and investigation had been undertaken.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the previous year and we were able to review these.

Serious events were raised by completion of a standard form which was submitted to the practice manager. Three serious events had been recorded in the last 12 months. We tracked all three incidents and saw that some investigation, discussion and action had taken place, although this was not always recorded clearly. We also saw that significant events were not always reviewed to minimise the risk of reoccurrence. One incident recorded a review date of November 2014, this date had passed with no review of the incident.

We saw an occasion when action had been taken as a result of serious event reporting. For example the practice had changed the method of issuing acute prescriptions following a miscommunication when a patient had run out of medication requested a prescription. The request was not processed promptly, which resulted in a complaint. Staff at the practice, introduced a process of completing a form for acute prescriptions to minimise the risk of miscommunication and delay when acute prescriptions were requested by patients.

We spoke with two members of practice nursing staff, both were able to recall a recent significant event that had been recorded.

A GP told us that they shared alerts such as National Patient Safety alerts with colleagues when relevant, although there was not a formal process for this. The GPs we spoke with were not able to give us an example of a recent patient safety alert received at the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible. The practice had a dedicated GP as the lead contact in safeguarding vulnerable adults and children. All staff we spoke with were aware of who the nominated safeguarding lead was.

Requires improvement

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children classified by social services as being at risk.

Nursing staff at the practice acted as a chaperone when required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The practice displayed notices advertising the availability of a chaperone if required.

Children who did not attend for immunisations were followed up by a health visitor when this was required.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures. The policy described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

The healthcare assistant administered vaccines using directions that had been individually assessed for each patient and fulfilled both legal requirements and national guidance. We saw that the healthcare assistant had received appropriate training and displayed appropriate knowledge to administer vaccines to patients.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept secure at all times and were handled in accordance with national guidance.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff had received infection control updates specific to their role. We reviewed records of the most recent practice audit which had been performed. We were told that this had been completed in October 2014, although the document was not dated. The audit had highlighted areas for improvements required to minimise the risk of patients or staff being exposed to infection. We saw that the audit had identified that the immunity status of relevant clinical staff to blood borne viruses was not known to either staff or the practice. Blood borne viruses are viruses carried in the blood that can be transmitted from one person to another via bodily fluids transfer. In the subsequent four months since the audit this issue had not been corrected.

The practice had a number of policies to promote cleanliness and control infection. These included infection control and specimen handling. There were procedure documents and flowcharts to support these policies to enable staff to plan and implement measures to control infection. For example we saw that clinical waste was separated from domestic waste. Staff were able to describe items that would be classified as clinical waste and how to dispose of them in a correct manner. There was a policy and procedure in case a member of staff suffered a needle stick injury.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

The practice did not have a formal written policy for the management, testing and investigation of legionella (a

germ in the environment which can contaminate water systems in buildings). The practice manager told us that she had been unable to obtain a legionella risk assessment as contractors had been unwilling to provide one.

Equipment

Staff we spoke with told us they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the date of last test. We saw evidence of calibration of clinical equipment. One example was a set of clinical weighing scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment. For example proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice manager told us about arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This was based on providing a minimum of two staff to perform reception and call answering duties. In periods of high activity or staff illness other members of staff were trained and experienced in how to provide reception and telephone duties. The practice manager told us that this helped to maintain the day to day staffing requirements and provided additional support in times of high demand on services.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We looked at records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice building was not owned by the GP partnership. The building was maintained and checked on a weekly basis by a maintenance worker appointed by the landlord. We saw that practice staff regularly checked equipment, medicines and emergency procedures to ensure these were fit for use in practise.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

A GP told us about the prescribing arrangements for patients who were at a higher risk of harm as they had expressed ideation of harming themselves. They told us that patients were assessed and supplied with weekly amounts of medication to minimise the risk of them taking an overdose of prescribed medication. The GP also told us that this gave both pharmacy and practice staff an overview of how often medication was being requested and that this may alert them if a patient was not collecting required medication.

On the day of inspection we saw two patients attend the practice within a short time frame with health needs that were urgent. We saw practice staff deal effectively with both patients. This involved emergency calls to the ambulance service, treatment and monitoring of the patients whilst awaiting the ambulance and handover of care to the attending ambulance crews. The practice was able to effectively deal with two patients who both had urgent health needs at the same time.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available at a secure central point. Equipment included oxygen therapy and nebulisation (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There was also a pulse oximeter (to measure the level of oxygen in a patient's bloodstream). All the staff knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available in a lockable carry box within a secure central area of the practice. These were comprehensive and could be used to treat a wide range of medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a patient suffers a seizure/fit) and hypoglycaemia (a very low blood sugar level). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Requires improvement

Are services safe?

The practice had a disaster recovery plan in plan to deal with unplanned events that may occur and would hinder operation of the practice. Each risk had been rated and mitigating actions recorded to reduce and manage the risk. The plan included details of alternative accommodation to operate the practice from in the event of a major issue with the existing premises. The document also contained details of who to contact in the event of specific issues, for example contact details for failure of the heating system.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received training in fire safety and fire drills were practised.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

All of the GPs and practice nurses at the practice we spoke with were open about asking for and providing colleagues with advice and support. A GP told us about a discussion he had held with the practice nurses to discuss best practice in the care of patients at the practice with a diagnosis of asthma. Following the discussion the team decided to change the method of how patients in the group could request inhalers that relieved the symptoms of asthma. The inhalers were taken off repeat prescription issue and required an acute prescription to be issued each time an inhaler was required. The GP told us this would give them a better insight into the control of a patient's asthma by checking how often an inhaler was requested when signing a prescription form.

We reviewed the most recent data available from the previous year 2013/2014 in the Quality and Outcomes Framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice had results significantly below the local average in six of the 46 clinical outcomes we looked at. Two of the outlying outcomes related to a higher expected number of patients being admitted to hospital in an emergency and three areas of higher than expected numbers of patients referred to specialist doctors at outpatient clinics. One outcome related to a lower than expected number annual reviews for patients who experienced poor mental health.

We spoke with a GP at the practice about the outlying outcomes. They told us that they are proactively reviewing patients on the practice register for poor mental health. We reviewed practice data that showed 63% of patients had been reviewed in the last year. This was significant improvement from the result of 25% achieved in the previous year. A GP told us that they expected the rates of reviews to be improved further as they had a high number of patient reviews appointments booked in the coming weeks.

Staff told us that they were working with partner agencies such as an integrated care team to reduce the number of patients admitted to hospital in an emergency. The integrated care team brings together staff from health and social care organisations with the aim of tailoring care to meet the needs of a patient and those close to them.

A GP told us that they review referrals to outpatient clinics in the form of peer review at clinical commissioning group (CCG) locality meetings that occurred every two months. They also told us this led to discussion and reflection on the available alternatives to referral.

The practice had introduced a system under a local improvement scheme with the local CCG to review the attendance of patients at the practice who had attended accident and emergency within working hours. The patients were contacted by the practice manager and offered an appointment with a GP to discuss their health needs. The GP told us that they were attempting to understand the reasons for patients choosing to attend accident and emergency, when on occasion their health needs could have been met by seeing a GP.

The practice had made recent improvements in the identification of patients with dementia. A GP told us that they believed the recording of patients with dementia had not previously been robust and had led to a much lower than expected number of patients with dementia being recorded. The practice had recently identified eight extra patients with dementia and had increased the practice register by 18%. The clinicians used a recognised system to test the cognition in patients who had displayed symptoms of dementia. Cognition testing ascertains the effectiveness of a person's ability and functions in areas such as memory, motor skills, reasoning and communication. If a patient displayed signs of cognitive difficulty, referral to a specialist would be required for diagnosis.

The practice had three QOF outcomes listed as a higher performance than average levels. An example was a lower than expected number of emergency admissions for

Requires improvement

Are services effective?

(for example, treatment is effective)

patients with a diagnosis of cancer. A GP told us they believed this was due to the continuity of the GPs at the practice as well as working in partnership with other health workers to meet the needs of patients in this group.

Management, monitoring and improving outcomes for people

Staff across the practice all had a role in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical audits. The practice showed us two clinical audits that had been completed in the last year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. An example was an audit looking at the identification of patients who had been prescribed medication that may be taken when a patient had a diagnosis of dementia. The purpose of the audit was to ensure that the patients had been recorded on the practice register for dementia. The audit also checked that patients had received the necessary referral to a hospital clinic for diagnosis. In October 2014 the practice audited the records of patients and identified two additional patients with a diagnosis of dementia. On re-audit in January an additional three patients were identified. The results of this audit were shared with practice staff and the importance of placing the correct diagnosis code on computer records shared. The effect on the five patients identified was to enable them to receive additional support by having an individualised care plan designed to meet their personal needs. The care plans were reviewed every three months to ensure that the needs of the patient were being met.

The practice did not undertake audits of the effectiveness of the minor surgical procedures provided. For example, infection or complication rates.

There was a protocol in place for repeat prescribing. In line with this, staff regularly checked that patients who received repeat prescriptions were reviewed by the GP.

We spoke with staff at the practice about the actions required when information is received that may mean the care or treatment for patients needs to be adapted, for example a medicines alert. This may be due to new evidence indicating one medicine should not be taken with another type of medicine. The GPs we spoke with were unclear on how this information would be actioned. We asked the GPs to give us a recent example of a medicines alert that had been received, but they were not able to recall a recent alert.

The practice had implemented principles of delivering appropriate individual care to patients who were approaching the end of their life. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area with the exception of higher than average rates of patients referred to outpatient clinics.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending annual courses required such as basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

We spoke with three administrative staff at the practice, all told us that they had a recent appraisal. We also spoke with two practice nurses. One of the nurses had not had an appraisal within the last year. The other practice nurse we spoke with had not had an appraisal for three years. Both told us they felt supported and could ask for assistance from members of the practice team if required. We have told the practice they should ensure that they provide consistent methods of appraisal to support to all members of staff.

The healthcare assistant at the practice told us that they had been supported to undertake further education at a local university. They told us that the practice had been proactive in funding the course and providing mentorship for the required elements of learning.

Requires improvement

Are services effective?

(for example, treatment is effective)

We checked the professional registrations of the GPs and practice nurses with the relevant professional regulatory body. These were all current and valid.

Working with colleagues and other services

The practice received blood tests results, x-ray results and letters from a number of partner organisations including the local hospital, 111 service and out-of-hours service. The results were received on a daily basis in either electronic or written form.

We saw that the system the practice used to process results and communications did not always meet the needs of patients.

The system used at the practice tasked all new communications to a computerised task folder. GPs were then required to read the information and task any required action to member of practice staff. For example if a follow up blood test was required, the GP could task a receptionist by computer to telephone the patient and arrange the blood test appointment.

We reviewed two computerised folders of communications and saw that one folder contained 65 communications. The other folder contained 78 communications. We reviewed five letters and saw no evidence or action that showed that the letters had been reviewed by a GP. For example, we saw a hospital letter dated 15 January 2015 where a requested action by a hospital consultant had not been followed up. A delay in reviewing or actioning health information could have serious consequences for a patient's care or treatment.

We spoke with a member of staff from an organisation who provided assessment and support to patients experiencing poor mental health. The member provided consultations sessions from a room at the practice, although they were not employed by them. The key worker told us that they had a positive working relationship with the practice team. They commented that the GPs were very accessible and would always make time available to discuss any concerns about patients registered there.

There was a weekly clinic at the practice run by a health visitor to offer advice to parents or carers of children. A GP had input into the clinic on a regular basis to perform a health check on recently born babies with the health visitor. The first set of immunisations for the baby were also provided at this clinic.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made all possible referrals last year through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and this was fully operational. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received. An example of this was, patients who were approaching the end of their life with a progressive condition had been supported to make decisions about the benefit and implications of receiving or not receiving resuscitation attempts in the event of them stopping breathing.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care

Requires improvement

Are services effective?

(for example, treatment is effective)

plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We reviewed practice records which showed that 77% of patients on the register with a learning disability had been reviewed in the last 12 months. The practice had improved the process of arranging follow up reviews for patients with a learning disability following poor review rates from the previous year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's consent was documented on a minor surgery template. The template recorded the relevant risks, benefits and complications of the surgery.

Health promotion and prevention

The practice followed guidance and local initiatives set by the CCG to meet the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The lead GP at the practice was a clinical director within the CCG and held an active role in commissioning and implementing health improvement measures within the local area.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The GPs we spoke with told us that they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic NHS health checks and offering smoking cessation advice to smokers.

The practice's performance for cervical smear uptake was 75%, which was just below the CCG and national average.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up as appropriate if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was at or above average for the CCG.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP National Patient Survey published in January 2015. The practice provided us with a copy of the results from their own survey undertaken with help from the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The survey was undertaken in June 2014 and expressed the views of 97 patients at the practice.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also comparable with the local and national average in its satisfaction scores on consultations with GPs with 92% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients at the practice rated the care given by the practice nurses at levels slightly above the clinical commissioning group (CCG) average. For example 84% of practice respondents said the nurse treated them with care and concern (CCG average 80%) and 93% of respondents said that they had confidence in the nurse who treated them (CCG average 87%).

The results of the practice's own survey showed that 92% of patients questioned were happy with the time practice staff spent understanding their concerns.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 44 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. A total of three cards mentioned it was sometimes difficult to get an appointment, one card also mentioned that the practice had not contacted a patient with abnormal blood test result.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk in another office which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients at the practice responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results showed that respondents rated the practice at higher satisfaction levels than the local and national average in these areas. For example, data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 91% felt the GP was good at explaining treatment and results. We also saw that the satisfaction levels with practice nurses in those areas were slightly below the local and national average. For example 71% of practice respondents felt the nurse involved them in their care. This result was 13% lower than the CCG average.

The results of the practice's own survey taken in June 2014 were positive. We saw that 92% of patients surveyed felt that their concerns are listened to and taken seriously.

Good

Are services caring?

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

We saw that patients had been supported to make decisions about the care they wish to receive or wish not to receive in the future. An example of this was a 'do not attempt cardio-pulmonary resuscitation directive' (DNACPR). This directive allowed the patient, relatives, carers and GPs to discuss the personal wishes of a patient approaching the end of their life, which meant resuscitation attempts may be inappropriate. A GP told us of the process of involving and supporting a patient and others close to them in such a difficult and emotional time. We saw records that showed such discussions had taken place and that this was recorded and shared with other partners who were involved in the patients care, for example community nurses and GP out-of-hours services.

Patient/carer support to cope emotionally with care and treatment

All of the survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88% of respondents to the national patient survey said they felt that the GP who treated them, did so with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were contacted where appropriate. A GP told us based on the individual circumstances a GP would call the families if appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice provided an additional service funded under a local improvement scheme by the CCG. The practice offered support to patients who had attended the accident and emergency department of the local hospital with a health problem that was not an immediate or urgent health need. A member of practice staff contacted relevant patients by telephoning them and discussing their concerns. The practice manager told us that the patient was offered an appointment with a GP to discuss their concerns if they wanted one.

Patients had access to home visits when appropriate and patients we spoke with on the day of inspection confirmed they could request a GP home visit if needed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. An example was the practice produced a leaflet to give to patients after they had a blood test. The leaflet explained the procedure for obtaining results. The PPG had suggested the introduction of a leaflet following comments from patients about misunderstanding the process for obtaining results.

Tackling inequity and promoting equality

The practice had access to telephone translation services for patients who did have English as their first language.

Facilities at the practice for the consultation and treatment of patients were all situated on the ground floor. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. There was a hearing assistance loop available for patients and visitors with hearing aids.

The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respecting diversity.

Staff at the practice told us that they had a good knowledge of the needs of the patients registered there. They gave us positive examples of when they had tailored their contact and treatment to suit an individual's need. An example was telephoning a patient with short term memory loss to remind them about an upcoming appointment.

We saw notes from a staff meeting that related to a discussion regarding patients who had a learning difficulty attending the practice to get an appointment as they did not understand the triage system or had difficulty in communicating. The practice team agreed to allow this group of patients to bypass the triage system so as not to distress them with a communication barrier on the telephone.

Access to the service

The practice offered appointments from 8am to 6:30pm on a Tuesday, Wednesday and Friday, 8am to 8pm on a Monday also 7:30am to 1pm on a Thursday. During all of the opening hours the reception desk and telephone lines remained staffed with the exception of the Monday 6:30pm – 8pm appointment session as this was for pre booked appointments only.

Three of the nine patients we spoke with commented that it could be difficult to get through to the practice by telephone at 8am in the morning. We received three comment cards that related to comments about difficulty in getting through to the practice by telephone at opening time. Two patients we spoke with and one comment card said that the delay for being called into an appointment can frequently be longer than 15 minutes.

Appointments could be booked in person, via telephone or via an internet appointment system for patients who had registered their details for this method.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were able to book appointments with a preferred GP up to two weeks in advance. We saw that all GPs had appointments available in the following days.

Telephone consultations were available for each GP at allotted times throughout the day. A GP commented this was particularly useful for patients with work commitments.

Requests for on the day appointments for health needs that patients felt were urgent were all triaged by an experienced nurse practitioner. When patients called in with urgent health needs, administrative staff recorded their details in the computer system. The nurse practitioner told us they called patients back in order. If a patient had a more urgent health need identified, they would be called first. The nurse practitioner told us that patients were offered telephone advice, an appointment or home visit as appropriate. Three of the patients we spoke with on the day of our inspection commented on the efficiency and effectiveness of the triage system and felt it worked well.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits also how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, their telephone call was transferred directly to the 111 service. Information on the out-of-hours service was provided to patients on the practice website and in the waiting room.

Longer appointments were available for those who needed them. For example review appointments for patients with poor mental health and those identified with complex needs.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice displayed clear information on how to raise a complaint in the waiting room, practice booklet and on their website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received six recorded complaints in the previous 12 months. We tracked three complaints and saw that all of these complaints had all been dealt with in a timely and open way. Five out of the six complaints received had been recorded from verbal comments made at the practice. One was a written complaint. An example of the practice responding to a complaint was a complaint concerning incorrect information on a poster displayed on the practice door relating to opening times. The poster was amended and the patient received an explanation and apology.

We saw no trends in the complaints received and saw that the practice had learned and acted on individual complaints.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a written vision, values or mission statement. We spoke with staff who described their personal aim to provide patients at the practice with a high quality and caring service. All of the staff with spoke with described their expectations of high standards in providing care and treatment to patients and displayed these on the day of our inspection. We spoke with nine patients and reviewed 44 Care Quality Commission (CQC) comment cards that showed the overwhelming majority of patients felt that practice staff delivered their aims.

Governance arrangements

We looked at the governance arrangements within the practice and found that there were weaknesses in the systems used that meant risks were not always well managed.

We saw examples in the practice where governance was not robust. An example was the process for handling communications from hospitals and other partner agencies. There was not a written policy or process for handling these communications. The staff we spoke with were clear that letters should be scanned and processed into an electronic computer system and had performed the task. The communications were then viewed by GPs and actions taken. On the day of our inspection this process had nearly 150 letters of communication outstanding to be reviewed. We saw dates on some of these computerised records spanned back over eight weeks. Practice staff told us that some of the records had been reviewed although not filed. We looked at records and found evidence of a delay in a patient being followed up.

The practice had a number of policies in place to govern activity and these were available to staff within practice files. We reviewed four policies and saw that they had been kept up to date, although we saw that they were not always followed. An example of this was the infection control audit that had been completed as directed by the infection control policy. Practice staff told us this had been undertaken in October 2014, although we saw no dates to reflect this entered on the document. The audit had been completed in pencil and had identified areas of risk within the practice that required action. For example the unknown immunity status of the clinical staff within the practice to blood borne viruses. This area of risk had not been mitigated by taking action to obtain the results of the immunity status of relevant staff within a four month time period following the audit.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards in most outcomes. In the outcome areas that were below the national average, the practice had taken action to improve performance. An example was adding additional appointments to review patients on the practice register for poor mental health as the practice had poor review rates in this area. In the year 2013/2014 25% of patients on the practice register for poor mental health had been reviewed on a yearly basis. On the day of our inspection the figure was 63%.

The practice manager told us that issues of governance were discussed at practice or clinical meetings as appropriate. We requested minutes from the practice and clinical meetings to confirm that governance issues were discussed. The practice was only able to supply two sets of minutes for the previous 12 months. The practice manager told us that clinical meetings happened every two months although minutes were not always taken. The two sets of minutes that we reviewed from April and October 2014 did not list any items of governance. The set of minutes we were provided with for the meeting in October 2014 recorded discussion surrounding the launch date for the NHS 111 telephone helpline changing. The NHS 111 service was launched in Staffordshire in October 2013, this evidence led us to believe that the minutes provided were not an accurate reflection of a meeting held in October 2014.

Leadership, openness and transparency

There was a leadership structure in place at the practice. All of the staff we spoke with were able to identify the key person for each lead role. For example, all knew who the lead person for safeguarding was.

The practice manager told us they operated an open door policy for staff to approach them with any concerns or problems. Staff confirmed an open culture and they felt able to approach the GPs or practice manager at any time.

Are services well-led?

Inadequate

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

A GP told us that the practice staff regularly met with neighbouring practices in the clinical commissioning group (CCG) to benchmark their performance also to share and learn from others.

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

Staff at the practice and members of the patient participation group (PPG) met on a three monthly basis to discuss issues concerning the operation of services at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We spoke with a member of the PPG and reviewed minutes of the meetings held. We heard and saw positive examples of improvement for patients at the practice following involvement of the PPG. An example was the system for offering triage call-backs for parents of young children had been modified. This followed comments made to the PPG from parents of school age children that it was difficult to receive a telephone call back when taking children to school. Following discussion with practice staff, the system was changed to allow the immediate offer of an on the day appointment for an unwell child.

Each GP undertook annual patient satisfaction surveys for use in their appraisals. One GP told us this provided invaluable feedback to enable them to reflect on their strengths and highlighted areas for improvement.

The practice had introduced a telephone triage system operated by an experience nurse practitioner. This was in response to patient comments surrounding difficulty in obtaining on the day appointments. Patients we spoke with on the day of our inspection and the comment cards we received were positive about this change and felt it was working well. We saw records of a practice discussion that detailing practice staff sharing ideas on how the triage system was working in the practice.

Management lead through learning and improvement

We spoke with staff at the practice about the support they received to maintain their clinical professional development through learning and mentoring. The practice healthcare assistant had told us they had received support from the practice team to develop through further education qualifications in healthcare. They also commented that they had received a high level of support in the form of mentoring from the nursing team.

We saw that the two practice nurses had not had recent appraisals. One of the nurses had not had an appraisal for three years. An appraisal is an opportunity to recognise and reinforce good performance, to identify and deal with poor performance also to identify and address any training needs. The practice as an employer had a responsibility to ensure that all staff equally were treated equally and to ensure that the employee had the appropriate skills and knowledge. All of the other staff we spoke with told us they had received an appraisal in the last 12 months. We have told the practice that they should ensure all staff receive regular appraisals relevant to their role.

The practice had not completed reviews of all recorded significant events. The practice did not have a consistent system for sharing the results of serious event or incident reviews as minutes were not always taken or absent for most months.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people who use services and others against the risks of inappropriate or unsafe care and treatment because serious event investigation, recording and information sharing was not completed on all occasions. Investigation had not always been completed in a timely way. Serious events were not reviewed to minimise the risk of reoccurrence. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not provided safe care and treatment because they could not demonstrate knowledge of recent medicines alerts or demonstrate that action had been taken following an alert to minimise the risk of medicines interacting. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not provided safe care and treatment because communications containing information about the care needs or treatment of patients had not been acted upon promptly. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not operated good governance because accurate records of meetings that discussed patients care and treatment and the management of the regulated activity were not always taken or were inaccurate. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not ensured safe care and treatment was provided because people who use the service and persons employed for the purpose of carrying out the regulated activity were not protected against the identifiable risks of acquiring a blood borne infection as the immunity of staff to such an infection was not known.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (a) (b) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the register person had not supported members of staff because appraisals and learning and development needs were not always identified, planned and supported. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.