

Meadow View Surgery

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?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to Meadow View Surgery	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12
Action we have told the provider to take	26

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Meadow View Surgery on 21 January 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing effective, caring and responsive services. It was rated as requires improvement for providing safe and well-led services. It was rated as requires improvement for providing services to the six population groups we report on: 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 dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Some risks to patients were assessed, however not all risk assessments were recorded.
- Risks relating to infection control and emergency equipment had not been carried out.
- Formal systems for checking medicines were not in place.
- Not all staff had received training appropriate to their roles, for example in infection control, fire safety, and chaperoning.
- Performance data showed patient outcomes were similar to averages for the locality, and we saw evidence that the practice were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and that they were involved in their care and decisions about their treatment.
- The practice had sought feedback from staff, patients, and the patient participation group, and had acted upon that feedback.
- The practice was above the CCG average for the number of patients who were satisfied with consultations with the GPs and nurses.

Summary of findings

- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested.
- The practice had a number of policies and procedures to govern activity, and staff were aware of how to locate these.
- There were regular practice meetings and minutes were recorded.

Importantly, the provider must:

- Ensure confidential patient records are stored securely.
- Ensure that all electrical equipment is regularly tested for electrical safety.
- Complete a comprehensive risk assessment to manage infection prevention and control, and provide staff with training relevant to their roles.

- Have a formal system in place to show that the expiry dates for all medicines in the practice have been checked.

In addition the provider should:

- Ensure all staff who act as a chaperone to patients are suitably trained.
- Ensure an automated external defibrillator (AED) is available, or undertake a risk assessment if a decision is made to not have an AED on-site.
- Ensure staff are up to date with fire safety training.
- Formalise the practice's vision and values and share these with patients and staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services as there were areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. The practice had identified risks to patients who used services, and we saw risk assessments relating to fire safety, business continuity, and the building and environment. However we did not see evidence to confirm that medicines were regularly checked for suitability of use; portable electrical equipment had not been tested; and a risk assessment for dealing with emergencies in the absence of an automated external defibrillator (AED) had not been carried out. There was also no evidence of audits or staff training in infection prevention and control. We found patients' electronic records were only accessible to staff, however patients' paper records were not stored securely. We also found that some staff had not received training in fire safety, and carrying out chaperone duties.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice had a process in place to follow-up patients discharged from hospital, and we saw that the protocols for actioning hospital communications was working well in this respect. There was evidence of completed clinical audit cycles to improve patient outcomes, and performance data showed patient outcomes were similar to averages for the locality. For example, last year's performance for immunisations was at or above the local average where comparative data was available. The practice were driving improvement in performance to improve patient outcomes. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and regular meetings were held.

Good



Are services caring?

The practice is rated as good for providing caring services. Data from the national patient survey 2014 and the CQC comment cards showed that patients rated the practice higher than others for several aspects of care. For example, the practice was above the CCG average for the number of patients who were satisfied with

Good



Summary of findings

consultations with the GPs and nurses. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, extra evening appointments were offered under a 'winter scheme' from January to March 2015, and longer appointments were available for patients who may need them. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice premises did not fully meet the needs of people with disabilities, and the practice were undergoing maintenance to improve the current facilities. The practice had sought feedback from staff, patients, and the patient participation group, and had acted upon that feedback. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and the patient participation group.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. Senior management were able to describe the practice's vision and a strategy, but not all staff was aware of this and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and staff were aware of how to locate these. There was a monthly practice meeting comprising of clinical and non-clinical topics, and these were minuted. Whilst there were some systems in place to monitor and improve quality and identify risk, improvements to medicines management, infection control, and the storage of patient records was required. The practice sought feedback from patients and staff, and had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events. Staff were supported to upskill and receive training relevant to their role, although we noted that some staff had not received training in infection prevention and control, and fire safety.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older people. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a lower percentage of patients over the age of 75 (3.1%) than the national average (7.6%). Nationally reported data showed that some outcomes for patients with conditions commonly found in older people were at or below the local and national averages. Staff were aware of where improvements were needed and had made changes to practice to improve these outcomes for patients. The practice offered personalised care to meet the needs of the older people in its population, for example all patients over the age of 75 had a named GP. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice also told us they had close working relationships with district nurses and heart failure nurses to discuss care planning for patients who required extra support.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions (LTC). The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff assisted the GPs in chronic disease management. Patients with long term conditions were invited to a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice population consisted of 28% who were children aged 0 to 16. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, health visitors were attached to the practice and attended

Requires improvement



Summary of findings

multidisciplinary meetings to discuss children at risk. There was a designated GP who led on child protection, and all staff were aware of their responsibilities for safeguarding children. Immunisation rates were similar to or above the local averages for all standard childhood immunisations. Appointments were available outside of school hours. Both antenatal and postnatal care was provided by the doctors. The practice also offered advice on contraception and sexual health.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). 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 offered online services to book appointments and request repeat prescriptions. Telephone consultations were also available. Extended hours were available for appointments on Tuesday and Wednesday evenings from 18:30 to 20:00. NHS health checks were offered to patients aged 40 to 75. The practice also provided a range of health promotion and screening services that reflected the needs for this age group, and health promotion material was available to patients within the practice and on the website.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. 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 carers and patients with a learning disability. It offered annual health checks to patients with a learning disability and records showed that four out of 10 of these patients had received such a check-up in the last 12 months. Longer appointments were also offered to patients with a learning disability. There were 33 patients registered as carers, and staff were aware of carers' needs and signposted patients to support services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to

Requires improvement



Summary of findings

recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The concerns which led to these ratings apply to everyone using the practice, including this population group.

Longer appointments were available for patients experiencing poor mental health. Annual physical checks and mental health reviews were offered to patients on the mental health register, and 26 out of 35 patients had a care plan in place. The practice provided patients experiencing poor mental health with information about how to access emotional support services.

Requires improvement



Summary of findings

What people who use the service say

We spoke with six patients, including a member of the patient participation group (PPG), on the day of our inspection. All were positive about the practice and their experience of the services provided. Patients said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment. They told us they were happy with the cleanliness of the environment and the facilities available. Patients said they were able to get an appointment when they needed one, and were able to see the GP of their choice. Urgent appointments were also available the same day.

We received 38 CQC comment cards and a letter from a member of the PPG. Feedback was positive about the service experienced. Patients said they felt the practice offered an excellent and professional service, and that staff were helpful and caring.

The National Patient Survey 2014 indicated respondents rated the practice above the clinical commissioning group (CCG) average in a number of areas, including consultations with the GPs and nurses. Eighty four respondents rated their overall experience of the practice as good, which was above the CCG average of 79%. However, it fell below the CCG average for waiting 15 minutes or less after their appointment time to be seen. The practice's 2014 survey revealed similar results.

Areas for improvement

Action the service **MUST** take to improve

1. Ensure confidential patient records are stored securely.
2. Ensure that all electrical equipment is regularly tested for electrical safety.
3. Complete a comprehensive risk assessment to manage infection prevention and control, and provide staff with training relevant to their roles.
4. Have a formal system in place to show that the expiry dates for all medicines in the practice have been checked.

Action the service **SHOULD** take to improve

1. Ensure all staff who act as a chaperone to patients are suitably trained.
2. Ensure an automated external defibrillator (AED) is available, or undertake a risk assessment if a decision is made to not have an AED on-site.
3. Ensure staff are up to date with fire safety training.
4. Formalise the practice's vision and values and share these with patients and staff.

Meadow View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor. The specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Meadow View Surgery

Meadow View Surgery provides GP led primary care services through a General Medical Services (GMS) contract to around 5,300 patients living in the surrounding areas of Northolt, Greenford, South Harrow, Southall and Ruislip. (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of Ealing Clinical Commissioning Group (CCG). The practice has a higher proportion of patients between the ages of 0-9 and 25-39, when compared with the England average. The proportion of patients over the age of 49 is lower than the England average.

The practice staff comprise of a female GP partner, a male GP partner, a nurse, a healthcare assistant, a practice manager, and a small team of reception / administration staff. The GP partners work 14 sessions. The nurse and health care assistant each work 29 hours per week. There are also district nurses and health visitors attached to the practice.

The practice is located in a converted residential property with two consulting/treatment rooms on the ground floor and two consulting/treatment rooms on the first floor.

The practice is open every weekday morning from 08:30, and closes at 18:30 on Monday and Friday, at 20:00 on Tuesday and Wednesday, and 13:30 on Thursday. Appointments are from 09:00 to 13:30 every morning, and 16:30 to 18:30 every weekday except Thursday. Extended hours surgeries are offered from 18:30 to 20:00 on Tuesday and Wednesday evening. Appointments must be booked in advance over the telephone, online or in person. The practice opted out of providing out-of-hours services to their patients. On Thursday afternoons and outside of normal opening hours patients are directed to an out-of-hours provider.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, treatment of disease, disorder and injury, and maternity and midwifery services. This is the only location operated by this provider. The provider had not been inspected before and there were no concerns about performance prior to the inspection visit.

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. The provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before 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 inspection on 21 January 2015. During our inspection we spoke with a range of staff including: the two GP partners; the practice nurse; the health care assistant; the practice manager; and two members of reception / administration staff. We observed how patients were being cared for and reviewed the treatment records of 12 patients. We sought the views of six patients on the day of inspection, including a member of the patient participation group (PPG). We reviewed 38 comment cards where patients and members of the public shared their views and experiences of the service, and received written feedback from another PPG member. We also reviewed the practice's policies and procedures.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a recent incident involving a vaccination error had been investigated, written up as a significant event, and shared with all staff. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and incidents. An incident book was used to log daily incidents. Significant event forms were accessible to staff on the practice's shared drive, and completed forms were sent to the GP partners for review.

There were records of significant events that had occurred during the last two years, and we reviewed the records of the four incidents that took place within the last 12 months. These reviews contained a summary of the event, risks identified, actions required, learning outcomes, and a review of the actions. For example, one incident we reviewed involved a patient accidentally collecting another patient's prescription as it had been attached to their own prescription. The error was identified by the pharmacist, who then informed the practice before the medicines were dispensed. As a result of this incident all staff handling prescriptions were instructed to check patients' information on each prescription before it is given out. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken. Urgent incidents were discussed with the staff involved as soon as possible. There was evidence that the practice had learned from significant events and that the findings were shared with all staff during the monthly

staff meetings. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice had a 'safety alerts protocol' which outlined the procedures for dealing with received alerts. Patient safety alerts were received by the GP partners and practice manager, and disseminated by email to relevant staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, the nurse told us about a medicine that had recently been withdrawn and how patients were seen so that an alternative medicine could be prescribed. Clinical staff also told us alerts were discussed informally and at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff had received relevant role specific training on safeguarding. For example, the GPs and nursing staff had received Level 3 child protection training, and non-clinical staff Level 1. We saw that two administrative staff who had yet to receive safeguarding training were booked to attend courses the following month. We asked members of medical, nursing and administrative staff about their most recent safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

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 subject to child protection plans.

There was a chaperone policy which was visible in the waiting room. (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). Clinical and non-clinical staff acted as chaperones. However, staff had not received training to be a chaperone and one non-clinical staff member we spoke to was unclear about the role, for example the importance of being able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were procedures for ensuring that medicines were kept at the required temperatures and the action to take in the event of a potential failure. Records dating back to 2008 showed that there had been no break in the cold chain. The practice manager and nurse told us that they regularly checked whether medicines were within their expiry date and suitable for use, however there were no records to confirm this. All the medicines we checked were in date and fit for use.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance.

The practice told us that the management of patients taking high risk medicines was carried out via a shared care protocol with the hospital or other specialist clinics. For example, patients taking methotrexate underwent monitoring at the hospital and a letter would be sent to the GP. Two patients we spoke with told us the practice had contacted them to see the GP when the specialist had changed their medicines.

The practice had a repeat prescribing protocol which set out the method by which a repeat prescription could be

issued, and the roles and responsibilities of staff within the practice. Administrative staff generated authorised repeat prescriptions. We found that the 'production and authorisation' section of the protocol needed amending to make it clear that administrative staff should refer requests for high risk medicines to the GPs, and the practice also needed to update the high risk medicines listed on the protocol. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored securely at the practice. A GP partner told us they kept a small number of prescriptions for use during home visits in their GP bag, and although the bag was not left unattended these prescriptions were not monitored. The partner agreed that the practice would consider an approach to manage this risk.

Cleanliness and infection control

The practice's premise was undergoing maintenance work at the time of inspection. We saw new flooring and window blinds had been fitted in some treatment rooms. We observed areas that had undergone maintenance work being cleaned prior to patients arriving at the practice. We saw cleaning schedules were 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.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, a receptionist was able to describe the procedures to take when handling specimens. Notices about hand hygiene techniques were displayed in toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice had also received an external risk assessment for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

The practice had a lead for infection control however we did not see evidence that they had undertaken training to enable them to fulfil this role. Whilst the practice infection

Are services safe?

control policy stated that all staff should receive infection control training, staff told us they had not received training. We also did not see evidence of any infection control audits to identify areas for improvement.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment had been calibrated in October 2014, and we saw equipment such as blood pressure monitors and baby weighing scales indicating the last testing date. However, the practice had not carried out testing of portable electrical equipment.

Staffing and recruitment

Recruitment checks were undertaken for new staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, and a criminal records check via the Disclosure and Barring Service (DBS) for all staff. We reviewed recruitment files for two new staff members and saw evidence that appropriate recruitment checks had been undertaken prior to employment. An induction programme was in place and all new staff underwent an induction, which covered areas such as health and safety, confidentiality, and role specific responsibilities.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. 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.

Monitoring safety and responding to risk

Staff were able to describe the systems and processes in place to manage and monitor risks to patients, staff and visitors to the practice. However, these risks had not always been formally recorded. For example, we did not see records for medicines management or dealing with emergencies. The practice had recorded risks relating to the building and environment. For example, the flooring in the waiting room and toilets required changing, the reception office required remodelling, and the entrance

pathway at the back of the building needed repairing. We were informed that the maintenance work being carried out was conducted out-of-hours and did not impact on the service.

The practice kept paper and electronic patient records. Electronic records were password protected and could only be accessed by staff. However, patients' paper records were stored on open shelves in the reception office and were therefore not secure. The registered manager told us that the office door could be locked, however we noted that the reception counter in the office did not have a screen and the office could be accessed despite the door being locked.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available, including access to medical oxygen. The practice did not have an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency) and had not undertaken a risk assessment with regards to the absence of an AED. When we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly.

Emergency medicines were stored securely in three out of the four consulting / treatment rooms and all staff knew of their location. The practice manager and the GPs told us that they regularly checked whether emergency medicines were within their expiry date and suitable for use, however there were no records to confirm this. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included evacuation planning and dealing with pandemics. Whilst risks such as computer and telephone failure, adverse weather, and access to the building had been rated according to their impact on the business, the mitigating actions to reduce and manage these risks were not documented.

The practice's last fire risk assessment had been carried out in 2013 and included actions required to maintain fire

Are services safe?

safety. The practice manager informed us that fire drills were practiced every six months, however there were no records to confirm this. There was also no evidence to confirm that staff were up to date with fire training.

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 the clinical commissioning group (CCG). The GPs told us they attended educational meetings held at the local hospital and with the CCG, and NICE guidelines were reviewed here. Information was then disseminated to staff during practice meetings. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks with the GPs, nurse, or health care assistant, and were being referred to other services when required. Current performance data showed that 83% of patients with diabetes had a blood pressure reading in the preceding 12 months of 150/90 mmHg or less, 78% had received a foot exam in the last 12 months, and 79% had received the seasonal flu vaccination. These figures were within the target range for the practice. Feedback from two patients with long term conditions confirmed they had received health checks at the practice, and were referred to specialist services when required.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling

clinical reviews, and managing child protection alerts and medicines management. The information collected was then collated by clinical staff or the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that were undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate what changes to treatment or care were made, and the audit repeated to ensure outcomes for patients had improved. We reviewed an audit on the management of patients with chronic obstructive pulmonary disease (COPD). The initial audit had been carried out in 2014, and a re-audit took place in 2015. The initial audit had indicated that, for example: 23% of patients were due for annual lung function tests; 40% did not have a record of inhaler technique in the last 12 months; 28% of patients were considered for referral for pulmonary rehabilitation following the audit; and 8% were due for the annual flu vaccine. The re-audit had shown patient outcomes had improved, with percentages lowered to 8%, 8%, 26% and 0% respectively. In addition, the re-audit showed that the treatment provided to 91% of patients on the COPD register was now compliant with NICE guidelines for COPD.

The GPs told us clinical audits were often linked to medicines management information. We reviewed an audit on repeat prescribing which showed that 54% of repeat prescriptions were linked with the correct diagnosis. The results were shared with the clinical team, and the re-audit showed that 100% of repeat prescriptions were now linked with the appropriate diagnosis.

The practice used the information collected for the quality and outcomes framework (QOF) and national screening programmes to monitor outcomes for patients. (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 achieved 89% of the total QOF target in 2013/14 (CCG and national average 94%). This included meeting the minimum standards for QOF in atrial fibrillation, heart failure, hypothyroidism, asthma, dementia, epilepsy and palliative care. It did not achieve all the standards for other areas under the clinical domain, which included coronary heart disease (achieving 51 out of 62 points) and diabetes (91 out of 107 points). The practice was aware of the outcomes being achieved and areas for improvement. We

Are services effective?

(for example, treatment is effective)

saw evidence that regular reports were generated to identify areas where performance was not in line with national or CCG figures, and staff confirmed this information was shared with them during practice meetings. Staff were also given responsibilities to improve patient outcomes. For example, the health care assistant carried out a daily check of patient records to identify those who required review under the QOF criteria. These patients were then booked to see the GPs, nurse or health care assistant depending on their condition.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The IT system also flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, for outpatient referrals.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed training records for seven members of staff and saw that all staff were up to date with attending courses for basic life support. However, we did not see evidence that these staff had received training in infection prevention and control, health and safety, or fire safety.

The GP partners had additional diplomas in family planning. They were up to date with their yearly continuing professional development requirements and had either 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was

proactive in providing training and funding for relevant courses. For example a receptionist had attended a health care assistant course, and an administrator was booked to attend a minute taking course.

The practice nurse and health care assistant had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines for the health care assistant, and cervical cytology for the nurse.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service either electronically, by fax, or by post. These were then scanned into patient records the same day, and the GPs were made aware of any urgent requests including out-of-hours reports, 111 reports and pathology results. The GP who saw these documents and results was responsible for the action required. The GPs also directed 'tasks' to other members of staff to action. For example, the nurse or health care assistant was informed if a patient required a blood test to monitor their condition. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice monitored their performance in many areas including emergency hospital admission rates. Data from the CCG confirmed that the practice's emergency admissions rate per 1,000 people for 2014/15 was 243, which was lower than the clinical commissioning group average. This was also a reduction from the practice's 2013/14 rate of 248. The practice had a process in place to follow-up patients discharged from hospital, and we saw that the protocols for actioning hospital communications was working well in this respect.

Multidisciplinary team meetings were incorporated into the monthly practice meeting to discuss patients with complex needs. For example, those with multiple long term conditions, older patients, patients from vulnerable groups, or children on the at risk register. The meetings were attended by health visitors, district nurses, and heart failure

Are services effective?

(for example, treatment is effective)

nurses to discuss care planning for these patients. The GPs also attended monthly CCG meetings where they could discuss clinical cases with psychiatrists, social workers, endocrinologists, and A&E clinicians.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs, including those in receipt of palliative care, with the out-of-hours services.

Electronic systems were also in place for making referrals via the 'referral facilitation service' and the 'choose and book' system, where referrals were screened to check they were appropriate and then forwarded to the relevant specialist service. If a referral was rejected the GPs would be made aware. Urgent referrals were faxed and staff would follow-up to ensure the referral had been received.

The practice had signed up to the electronic Summary Care Record system. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). We were told patients were offered the choice to opt out if they did not want their records shared in this way.

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. 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. Staff told us how patients were supported to make their own decisions and how these should be documented in the medical notes. We were shown 12 patient records where consent had been recorded.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care 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 a care plan which was up to date and had been comprehensively completed. 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice, and these were carried out by the nurse or health care assistant. The GPs were informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering advice on diet and alcohol intake, and smoking cessation advice to smokers. The nurse also described her role in offering patients support with contraception and sexual health. A range of health promotion leaflets was available to patients in the waiting room and consulting rooms.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. Practice records showed four out of 10 had received a check up in the last 12 months. Annual physical checks and mental health reviews were offered to patients on the mental health register, and 26 out of 35 patients had a care plan in place. The practice had a palliative care register and there were three patients currently listed on the register. These patients were offered further support in line with their needs. For example, a GP provided patients who were extremely ill with a direct contact number, so they could call him in emergencies. This was in addition to the out-of-hours number.

The practice's performance for the cervical screening programme was 81%, which was similar to the clinical

Are services effective?

(for example, treatment is effective)

commission group (CCG) average 78%, and national average 83%. Staff would follow up patients who did not attend. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice nurse had responsibility for monitoring childhood immunisations and following up patients who did not attend. If a child did not attend a number of appointments the practice would inform the health visitors.

Last year's performance was similar to or above average for immunisations where comparative data was available. For example, childhood immunisation rates for the vaccinations given to under twos was 92% and five year olds was 97%. These were both above the CCG averages. Flu vaccination rates for the over 65s were 72% (CCG average 73%), and at risk groups 62% (CCG average 52%).

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 2014 national GP patient survey (107 responses received), a patient satisfaction survey carried out by the practice in January 2014 (142 responses received), and patient feedback received for the GP partners' annual appraisals in 2014. The evidence from 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 2014 national GP patient survey showed that 84% of respondents described their overall experience of the practice as 'fairly good' or 'very good'. This was above the clinical commissioning group (CCG) average of 79%.

Data from the 2014 national GP patient survey showed that the practice was above the CCG average for patient satisfaction scores on consultations with the GPs and nurses. For example, 88% of respondents said the GP was good at listening to them (CCG average 83%) and 91% said the GP gave them enough time (CCG average 80%). Satisfaction scores for consultations with the nurses showed that 81% of respondents said the nurse was good at listening to them (CCG average 72%), and 79% said the nurse gave them enough time (CCG average 72%). Patient feedback from the GP partners' appraisal showed that patients were highly satisfied with the care they received and said the GPs were helpful and good listeners.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 38 completed cards and a letter from a member of the patient participation group, and most comments were positive about the service experienced. Patients said they felt the practice offered an excellent and professional service, and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients, including a member of the patient participation group, on the day of our inspection. All these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We found privacy screens were not available in all

consulting / treatment rooms to ensure patients' privacy and dignity was maintained during examinations, investigations and treatments. We spoke to the registered manager about this and they informed us that the practice had purchased and were awaiting further screens for all consulting rooms. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that a room located away from the waiting area could be utilised to prevent patients overhearing potentially private conversations between patients and receptionists. There was also a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The 2014 national GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national patient survey showed 81% of practice respondents said the GP involved them in care decisions, and 86% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area values of 70% and 78% respectively.

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 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 did not see notices informing patients this service was available. Staff told us that most patients brought a family member to assist with interpreting, however they were

Are services caring?

aware that this may not be appropriate in some circumstances and an interpreter would then need to be booked. Staff told us that they spoke languages other than English, such as Tamil, Gujarati, Hindi, Panjabi, Swahili, Swedish and German. We observed reception staff communicating with a number of patients in Tamil.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection told us they received emotional support from the practice. Comment cards we received also highlighted that staff were caring when patients needed support with certain health conditions.

Notices and leaflets in the patient waiting room told patients how to access a number of support groups and organisations. The practice currently had 33 patients

registered as carers, and the practice's computer system alerted GPs if a patient was a carer. Staff were aware of carers' needs and told us that they were offered an annual health check and the flu vaccine. We also saw information in the waiting room available for carers to ensure they understood the various avenues of support available to them.

The practice manager told us that if families had suffered a bereavement the practice sent a letter of condolence, and if they contacted the practice they could speak with a GP over the phone or arrange an appointment. Patients were also offered referral to emotional support services such as Improving Access to Psychological Therapies (IAPT). There were notices in the waiting room signposting patients to support organisation such as a drug and alcohol service, and a mental health well-being helpline.

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 patient's 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. For example, the practice were involved in a 'winter scheme' whereby extra appointments were offered to patients on Monday evening from January to March 2015.

The GPs told us they engaged with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw the minutes from the most recent CCG meeting attended by a GP partner, where topics discussed included local hospital services, primary care enhanced services, and integrated care within the CCG area. The practice also received a monthly newsletter from the CCG, and we saw examples of how this was shared with all staff.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the need to review and improve the emergency appointment system had been identified by the PPG in 2014, and as a result patients were now given a specific time to attend rather than a walk-in system. Another suggestion that had been implemented was the removal of a large tree stump in the back garden to improve access to the premises. The practice recognised that there were improvements to be made to accessing the premises and they were actively pursuing this. A member of the PPG told us that the practice discussed the actions they had taken to improve the service and areas that were outstanding at PPG meetings.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, it provided services for asylum seekers and refugees. The majority of the practice population could speak English but staff told us there was also a high volume of Tamil speaking patients. Staff spoke languages other than English, and could assist with interpreting in Tamil, Gujarati, Hindi, Punjabi, Swedish, German, and Swahili. Access to telephone translation services were also available when needed. Longer

appointments were available for people who may need them, for example those receiving palliative care or experiencing poor mental health, and staff told us they tried to book these appointments around lunchtime, or at the end of a session in case the consultation overrun.

An environmental audit carried out by an external company stated that the premises was constructed prior to any compliance towards the Disability and Discrimination Act (DDA), and therefore the premises did not fully meet the needs of people with disabilities. The front of the premises had not been adapted to meet the needs of patients with mobility difficulties and therefore patient access to the building was via the back entrance. The audit identified that whilst there were no handrails on the ramp at the back entrance, the ramp could easily be negotiated with assistance. An alert on the computer system would notify staff when a patient who required assistance was attending the practice. Staff told us they assisted patients who were partially sighted and those with mobility difficulties. There was no lift access to the first floor of the building, therefore patients with mobility difficulties were seen in one of the two ground floor consulting rooms. A patient toilet and baby changing facilities were available however, the environmental audit identified that the toilet was not fully compliant with the DDA as it was not spacious enough to turn a wheelchair and there was no emergency pull cord. The practice were planning to renovate the toilet as part of the ongoing building work.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. For example, for patients who were housebound, receiving palliative care, or patients with learning disabilities.

Patients could choose to see a male or female GP. The practice had an equality and diversity policy in place, however staff had not received any training.

Access to the service

The practice was open every weekday morning from 08:30, and closed at 18:30 on Monday and Friday, at 20:00 on Tuesday and Wednesday, and 13:30 on Thursday. Appointments were available from 09:00 to 13:30 every

Are services responsive to people's needs?

(for example, to feedback?)

morning, and 16:30 to 18:30 every weekday afternoon except Thursday. The practice's extended opening hours from 18:30 to 20:00 on Tuesday and Thursday evening was particularly useful to patients with work commitments.

Information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Patients were directed to an out-of-hours provider, local walk-in centres, or the NHS 111 service.

Children aged 16 were automatically booked in by reception and were seen the same day. Emergency appointments were available in the morning and afternoon from 10:00-11.30 and 14:00-15:00. Longer appointment times with the GPs were available for those who may need them, including patients with learning disabilities, those experiencing poor mental health, patients with complex conditions, families, and for antenatal and postnatal care. The nurse and HCA also allocated longer appointments for diabetes and asthma reviews, smoking cessation, NHS health checks, weight management, and ear syringing. Home visits were made to the 27 housebound patients by a named GP, and to those patients who needed one.

The 2014 national patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example: 81% were satisfied with the practice's opening hours compared to the CCG average of 72%; 72% described their experience of making an appointment as good compared to the CCG average of 68%; and 71% said they could get through easily to the surgery by phone compared to the CCG average of 67%. However, 36% of respondents said they usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 55%. The practice's survey revealed similar results. We spoke to the practice manager and a GP partner about this, and they told us this was partly due to the previous emergency appointment system whereby patients were seen on a first come first served basis. Following consultation with the PPG the practice took action and patients were given an allocated time slot to attend their emergency appointment.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent and this was usually with the GP of their choice. Routine appointments could be booked in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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. The practice manager was the designated responsible person who handled all complaints in the practice. Complaints were discussed at staff meetings and staff we spoke with were able to outline what to do if a complaint was made to them. Staff told us that wherever possible they tried to de-escalate problems and deal with concerns immediately.

We saw that information was available in the waiting room to help patients understand the complaints system. 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.

We looked at four complaints received in the last 12 months. These were verbal complaints and had been dealt with in a timely way. The practice reviewed complaints annually to detect trends. We looked at the report for the last review and no trends had been identified. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. There was evidence that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. A patient participation group member also confirmed that the practice provided feedback to them with regards to complaints and issues being raised.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice did not have a formalised vision or strategy, and practice values had not been documented or circulated to staff. Senior management were able to describe the practice's vision and strategy for improving services provided for patients and ensuring the practice's premises and environment were safe and fit for purpose. There was also a focus on the proactive management of long-term conditions. Other staff spoke about the importance of providing patient-centred care, however they were not aware of a formalised vision and strategy for the practice or their responsibilities in relation to it. We did not see any information on values displayed within the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive of any computer within the practice. We looked at a number of these policies and procedures, including those relating to, health and safety, infection control, safeguarding, complaints, chaperoning, referrals, significant events, repeat prescribing, and business continuity. Most policies and procedures we looked at contained up to date details, however some policies (safeguarding, chaperoning, business continuity) were not dated and we could not identify when they had last been reviewed.

There was a clear leadership structure with named members of staff in lead roles. For example, for infection control, safeguarding, complaints, and the Quality and Outcomes Framework (QOF). We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP partners and practice manager took leadership roles for overseeing that the systems in place to monitor the quality of the service were consistently being used. Another employee was responsible for reviewing QOF data to measure the practice's performance. The QOF data for this practice showed it had achieved 797 points out of a total of 900 points for the year 2013/14, which was below local and national averages. The management told us they

were aware that their performance with QOF required improving. We saw that QOF data was regularly discussed at monthly team meetings and staff were given action plans to maintain and improve outcomes.

The practice also carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a prescribing audit ensured that patients who were given a repeat prescription had the correct clinical diagnosis linked to their prescription. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice also regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed some risks to patients, staff and visitors to the practice. For example, risks relating to fire safety, business continuity, and the building and environment had been documented. However, risks relating to infection control and emergency equipment had not been carried out.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including those for recruitment, induction, confidentiality, and whistleblowing that were in place to support staff. There was no staff handbook, however staff were referred to the practice's policies and procedures on the shared drive of any computer within the practice.

Leadership, openness and transparency

The partners and the practice manager were visible in the practice and staff told us that they were approachable and listened to all members of staff. Information was cascaded from management to staff effectively, and staff told us they were involved in discussions about how to develop the practice and improve the service.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff said they felt respected, valued and supported in their roles.

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

Are services well-led?

Requires improvement 

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

The practice encouraged and valued feedback from patients. The practice carried out an annual patient survey and we were shown the results from 2014. The practice also gathered feedback from patients via the GP partners' appraisals 2014, complaints received, and through the patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The PPG was active and met with the practice every three months. Meetings were scheduled in the mornings and evenings to accommodate a variety of attendees. We spoke with one member of the PPG and received written feedback from another, and both were very positive about the role they played and said they felt engaged with the practice. One member told us that suggestions made were implemented promptly where possible. We saw evidence that the practice had reviewed its results from the national GP survey, and patient and PPG feedback to see if there were any areas that needed addressing. For example, some patients had said it was difficult to book an appointment in advance. The practice had spoken to the PPG about this and explained that there was a high level of patients who did not attend for their appointments, preventing other patients from booking these slots. As a result staff opportunistically informed patients about the importance of cancelling appointments if they could not attend, and the practice displayed the monthly figures for appointments that were missed to raise patient awareness and improve access to the service. The PPG had suggested the implementation of a newsletter which could also include this information.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around the IT system and that this had been arranged with the practice manager and an external company. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff also told us that they could request further training to develop their roles. There was evidence that the practice had supported a receptionist to undertake training as a health care assistant. A receptionist also told us that they had been sent on courses related to their role. However, some staff had not received training in infection prevention and control, fire safety, or chaperoning.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings, or sooner if urgent, to ensure the practice improved outcomes for patients. We spoke to clinical and non-clinical staff and they were all aware of recent incidents that had occurred at the practice.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that electrical equipment used for providing care or treatment to a service user had not been tested for electrical safety. We found no formal system in place to show that medicines were checked for safety and suitability of use. We found that the registered person had not assessed the risk of the spread of infections, including those that are health care associated, and staff had not received training to prevent, detect or control the spread of infection. This was in breach of regulations 13 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(e)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: We found the registered person did not ensure that service users' records were stored securely. This was in breach of regulations 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.