

Dr Datta and Partners

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Datta and partner on 14 July 2015.

Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, and well led services. The concerns which led to these ratings apply to everyone using the practice, including all population groups. Therefore it also required improvement for providing services for the older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), those people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia). It was good for providing a caring and effective and responsive service.

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. Information about safety was recorded, but was not monitored and reviewed appropriately.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks, emergency equipment and medicines.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available, but was not left accessible to patients in the waiting area.
- 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.

Summary of findings

- The practice had a number of policies and procedures to govern activity, most of these were in date but some required inclusion of dates. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.

The areas where the provider must make improvements are:

- Ensure staff are appropriately trained to carry out chaperone duties.
- Ensure that all staff who carry out chaperone duties have a DBS check.
- Ensure that all clinical staff have a DBS check undertaken by the practice and reception and administration staff are risk assessed.
- Ensure that the systems and procedures for checking and monitoring emergency drugs and equipment are monitored to determine they are effective.
- Ensure that emergency equipment is stored in a safe place accessible to all staff in an emergency.
- Ensure that all staff have regular appraisal with documented outcomes.
- Ensure that all required pre-employment checks are carried out and recorded in staff files.
- Ensure that a system is introduced to track prescription pads used for hand written prescriptions.
- Ensure a means of reviewing and mitigating and recording all risks in the practice.
- Introduce notifications in the waiting area to inform patients that interpreters are available.
- Ensure the practice zero tolerance poster is in a place which can be easily viewed by all patients
- Ensure that the complaints procedure is advertised in the practice for patients to see.
- Ensure that all complaints and comments are formally recorded and reviewed and shared with all staff.
- Ensure that each room has a cleaning schedule to demonstrate daily cleaning by clinical staff.
- Introduce an inventory of medicines kept at the practice
- Introduce measures to encourage patients to stand back from the reception desk when other patients are being seen.
- Advertise to patients the facility to speak to a member of reception staff in private.
- Review policies and procedures so they reflect current practice.
- Ensure that all staff undertake the equity and diversity training available to them.
- Ensure that up to date patient group directives (PGDs) are available in the practice.
- Ensure that vision for the future development of the practice is formally shared with staff.
- Ensure that all significant events are captured and recorded formally to enable review and shared learning.

Action the provider SHOULD take to improve:

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 are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented and monitored well enough to ensure patients were kept safe. For example, although the emergency medicines were being checked and current medicines were available, expired medicines had not been removed.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. 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. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for most staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that 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 decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible with the exception of interpreter and private consultation information. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a

Good



Summary of findings

named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand but required to be more easily accessible such as in the waiting area. Evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. There was no documented leadership structure but most staff felt supported by management and knew who to approach with issues. The practice had a number of policies and procedures to govern activity, but some of these were not dated and required a review. Specific governance meetings were not held and any governance issues were discussed ad hoc and at a quarterly meeting. The practice sought feedback from patients and whilst they did not have a patient participation group (PPG) they had patient representatives who attended CCG meetings to take their views for consideration regarding the practice and the services it offered. However, the daily comments log left in reception was not formalised and a more formal process for recording and review is required. Staff records were incomplete and did not contain evidence of pre-employment checks and inductions and not all staff had received regular performance reviews.

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 provider was rated as requires improvement for safety and for well-led. 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.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for safety and for well-led. 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 these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Requires improvement



Families, children and young people

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The provider was rated as requires improvement for safety and for well-led. The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). 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 that reflects the needs for this age group.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated as requires improvement for safety and for well-led. 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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Requires improvement



Summary of findings

What people who use the service say

We spoke with four patients during our inspection and reviewed 34 comment cards that patients had left in the practice for us. Three of the patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us the doctors were caring and treated them with kindness. One patient expressed experiencing difficulty in getting an appointment.

The comment cards we received were all positive with the exception of four who commented on difficulty in getting an appointment. However, the majority of patients expressed satisfaction and positive comments with the service regarding their care and treatment at the practice.

The National Patient Survey reported very positive responses from patients regarding their care from the practice with results above the local and national average in all areas.

Areas for improvement

Action the service **MUST** take to improve

- Ensure staff are appropriately trained to carry out chaperone duties.
- Ensure that all staff who carry out chaperone duties have a DBS check.
- Ensure that all clinical staff have a DBS check undertaken by the practice and reception and administration staff are risk assessed.
- Ensure that the systems and procedures for checking and monitoring emergency drugs and equipment are monitored to determine they are effective.
- Ensure that emergency equipment is stored in a safe unlocked place accessible to all staff in an emergency.
- Ensure that all staff have regular appraisal with documented outcomes.
- Ensure that all significant events are captured and recorded formally to enable review and shared learning.
- Ensure that the recruitment policy is followed and all relevant pre-employment checks are carried out and recorded in staff files.
- Ensure that a system is introduced for use of hand written prescription pads to ensure they are recorded and signed for when used.
- Ensure a means of reviewing and mitigating all risks in the practice.
- Develop a clear vision and structured plan for the future development of the practice and share with staff.

Action the service **SHOULD** take to improve

- Introduce notifications in the waiting area to inform patients that interpreters are available.
- Ensure the practice zero tolerance poster is in a place which can be easily viewed by all patients
- Ensure that the complaints procedure is advertised in the practice for patients to see.
- Ensure that all complaints and comments are formally recorded and reviewed and shared with all staff.
- Ensure that each room has a cleaning schedule to demonstrate daily cleaning by clinical staff.
- Introduce an inventory of medicines kept at the practice
- Introduce measures to encourage patients to stand back from the reception desk when other patients are being seen.
- Advertise to patients the facility to speak to a member of reception staff in private.
- Review policies and procedures so they reflect current practice.
- Ensure that all staff undertake the equity and diversity training available to them.
- Ensure that up to date patient group directives (PGDs) are available in the practice.
- Ensure that vision for the future development of the practice is formally shared with staff.
- Ensure that all significant events are captured and recorded formally to enable review and shared

Dr Datta and Partners

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 and a practice manager specialist adviser.

Background to Dr Datta and Partners

Dr Datta and partner provides medical services to patients in Wellingborough and surrounding areas. The practice provides services under a personal medical services (PMS) contract to a population of approximately 3,900 patients. There are two GPs partners, one male and one female and a regular female locum GP. They employ two practice nurses and a practice nurse from another surgery who attends once a week to provide care in diabetes and asthma. There is one health care assistant, a practice manager, who are supported by a team of reception and administrative staff.

The practice operate from the ground floor of a purpose built modern two storey building in Wellingborough, which accommodates a pharmacy and another GP practice and other services. The practice population is made up of a slightly higher than average number of patients between the ages of 0 and 4 years, 25 to 30 years and 45 to 60 years. Data indicates that the area has a slightly above average level of deprivation.

The practice is open between 8am and 6.30pm from Tuesday to Friday and from 8am until 7.30pm on Mondays. When the practice is closed, a message is left on the answerphone with a number to contact in an emergency.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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

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

Detailed findings

- 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 hold about the practice and asked other organisations to

share what they knew. We carried out an announced inspection on 14 July 2015. During our inspection we spoke with a range of staff, the practice manager, reception and administration staff, GPs and the health care assistant. We also spoke with patients who attended the practice and observed how staff assisted patients during this time. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used some information to identify risks and improve patient safety. For example, national patient safety alerts as well as a daily log book which was kept in the reception area where staff recorded any incidents, issues, complaints or comments. We noted that some events recorded in the daily log book were potentially significant events but these had not been transferred to the significant event log maintained by the practice. There were two official significant incidents formally documented in the last year. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there had been an incident where sharps had been incorrectly disposed of and we saw that appropriate action had been taken.

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 appropriately.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents although this was not robust. We reviewed records of the two significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were discussed at practice meetings as and when they occurred but the GPs told us they would also discuss them with the member of staff involved. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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.

We tracked the two formally reported incidents and saw records were completed in a comprehensive and timely manner and one was still ongoing. We saw evidence of action taken as a result of one of them and that the learning had been shared. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated to practice staff by email from the practice manager. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, 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 an appointed dedicated GP as the lead in safeguarding vulnerable adults and children. The lead GP had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

We saw signs in the clinical rooms informing patients that a chaperone was available if required. There was no chaperone policy and staff we spoke with who carried out chaperone duties told us they had not had formal chaperone training, however, they could demonstrate they knew what to do when carrying out these duties. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We also noted that there was no Disclosure and Barring Service (DBS) check or risk assessment for the practice manager who carried out chaperone duties when necessary. They told us they did have one but it was not available at the practice for us to confirm. We also noted that the DBS checks for the nursing staff were from previous employers.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP gave examples to demonstrate

Are services safe?

the liaison which took place with partner agencies and evidence of involvement in a serious case review. They held meetings with the multi-disciplinary team including health visitor and midwife every three months to discuss vulnerable children.

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 was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

There were processes in place to check emergency medicines were within their expiry date and suitable for use. However, whilst the process was being undertaken, the member of staff had restocked expired medicines but had not removed the expired stock and arranged appropriate disposal. We also noted there was one month when they had not been signed for. Therefore, whilst there were adequate stocks of medicines all in date, there were also expired medicines which could have been administered. The practice kept a limited supply of other medicines which were stored securely, but they did not keep a stock control and therefore could not monitor or account for all medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers were stored appropriately in line with national guidance, however, whilst hand written prescriptions pads were stored securely there was no system to track these pads in line with national guidance.

The GPs told us that they carry out medicine management reviews and compared their performance with local practices, for example antibiotic prescribing. We saw that the practice was in line with other practices in the local CCG area.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. Staff

who dealt with repeat prescriptions told us about the system they followed and demonstrated knowledge of the importance of following the correct procedure for high risk medicines.

The practice manager told us the nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We were unable to view a copy of up to date PGDs during our inspection although the practice manager told us that the nurses had them. The practice manager told us that the practice nurses did not carry out childhood immunisations as this was done by the health visiting service. However, they did provide travel and flu vaccination and we saw they had been trained in these areas.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there cleaning was carried out by contract cleaners and that nurses were responsible for keeping their rooms clean during the day. We saw cleaning records and the practice kept a book which communicated any cleaning issues to the contractors and was checked on a daily basis. 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We noted that protective gloves and a chlamydia swab had expired and had not been removed and disposed of. We also noted that in one of the treatment rooms a large sharps box was kept on the floor and was accessible to children, exposing them to potential risk of injury.

The practice had a lead from each staff group for infection control, but the main leads were one of the GPs and a practice nurse. Infection control training had been undertaken by all staff although we did not see evidence of this for the GPs. We saw evidence that an infection control audit had been undertaken in October 2013 and no areas had required action.

Are services safe?

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Legionella testing had been carried out by the landlord and the practice had a copy of actions they needed to undertake to reduce the risk of Legionella infection (Legionella is a bacterium which can contaminate water systems in buildings). The practice manager told us that they carried out the recommendations weekly, for example turning on the showers. However, they did not record this formally.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out their role. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed that this had been carried out in March 2015. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was April 2014. A schedule of testing was in place from an external company. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff which had been reviewed in February 2015 but had not been followed at the last recruitment as this was prior to this date. The practice manager told us they would be following the new policy for any new recruit in the future. Records we looked at were incomplete and did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, some clinical staff had not had Disclosure and Barring Service (DBS) checks undertaken and the practice had accepted the one from their previous employer and there was no DBS check, references or photo identity seen for the most recently appointed nurse. (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). There were no contracts of employment, or references on any staff files we looked at.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff 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

The practice had systems, processes and policies in place to manage and monitor some risks to patients, staff and visitors to the practice. These included regular checks of the building, and the environment, but systems for medicines management, staffing and dealing with emergencies were not effective and there was no mechanism to check the effectiveness of the systems in place. Health and safety information was displayed for staff to see but did not identify the health and safety representative.

Identified risks were recorded individually. Each risk that had been identified was assessed and but these were not always recorded, for example, the legionella prevention measures which we were told were undertaken but not recorded. They had carried out risk assessments on the car park, building, infection control, fire and first aid and display screen equipment, but there were areas not assessed such as the emergency equipment being in a locked room.

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 oxygen and an automated external defibrillator (used in cardiac emergencies) together with emergency medicines. However, whilst they included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia they were all located in a locked room and therefore not easily accessible in an emergency as they required a member of staff who held the key to open the door. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Are services safe?

A system was in place to check whether emergency medicines were within their expiry date and suitable for use. However, the checking system was not effective or monitored as we found expired medicines in the emergency trolley. We checked and saw that the pads for the automated external defibrillator were within their expiry date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified

included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was not dated and did not contain a review date.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from 'Pathfinder' which were produced by the CCG in line with the National Institute for Health and Care Excellence (NICE) guidelines. We saw that guidance was easily accessible in all the clinical and consulting rooms. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

GPs 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 and were being referred to other services when required. One GP had recently undertaken additional training in diabetes to improve their service to patients with this condition. GPs told us that new guidelines and changes were discussed at the multi-disciplinary meetings.

The GPs told us they lead in specialist clinical areas such as diabetes, minor surgery and obstetrics and gynaecology. The practice also employed a practice nurse from another GP practice one afternoon a week who specialised in diabetes and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders and diabetes. Our review of the clinical meeting minutes confirmed that this happened.

The practice identified patients who were at high risk of admission to hospital, those who regularly attended A&E, and frequent callers to the out of hours service. Meetings were held with the district nurses, and included liaison with AgeUK and GPs to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. AgeUK is a registered charity which helps people

enjoy later life. They do this by inspiring, supporting and enabling people. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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 practice showed us four clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit, for example in the management of patients with epilepsy. Other examples included audits to confirm that the GPs who undertook contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information or as a result of information from 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. For example, we saw an audit regarding the chronic obstructive pulmonary disease where care reviews had been audited. They also reviewed prescribing of analgesics and nonsteroidal anti-inflammatory drugs and compared prescribing trends with local practices. The practice met every two months with the medicines management team to discuss and review prescribing.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This

Are services effective?

(for example, treatment is effective)

practice had maximum achievement in all clinical areas except diabetes and osteoporosis which was significantly below the CCG and national average, however, the practice were aware of this and were working towards improvement.

Specific examples to demonstrate their achievement included:

- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related and hypertension QOF indicators was better than the national average.
- The dementia diagnosis rate was above the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example, one of the GPs had undertaken a diploma in diabetes to help improve achievement and told us this was work in progress. However, they also told us they had some issues of non-compliance from patients due to cultural issues which may have contributed to low uptake. It achieved 97.8% of the overall total QOF target in all areas in 2014, which was above the national average of 94%.

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. GPs, administration and reception staff and the health care assistant spoke positively about the culture in the practice around quality improvement, although we were not able to clarify this with the nursing staff as they were not present.

The practice's prescribing rates were similar to other practices in the CCG. There was a protocol for repeat prescribing which was in line with the CCG prescribing guidelines. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had weekly multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital. Structured annual reviews were also undertaken for people with long term conditions such as diabetes and COPD.

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 practices in the area. This benchmarking data showed the practice had outcomes that were comparable to others in the area. For example, in maintaining the blood glucose levels of patients with diabetes within an acceptable level.

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 mandatory courses such as annual basic life support. The two GP partners had specific skills and interest in minor surgery, diabetes, gynaecology and paediatrics. The GPs were up to date with their yearly continuing professional development requirements and either have 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 saw that the administrative staff had undertaken annual appraisals but the practice manager had not been appraised since 2011. Appraisals which had been completed contained some actions and staff we spoke with told us that the practice did provide training if they requested it. For example, one of the administration staff was completing a course in management. We were also not able to establish if the nurses had received appraisal as there was no record in their staff file although the GPs told us they had been completed.

Job descriptions outlining staff roles and responsibilities were seen and had been emailed to individual staff. We saw that staff were adequately trained to carry out the tasks in their role. The practice nurses carried out routine

Are services effective?

(for example, treatment is effective)

practice nurse duties. Long term conditions were managed by a nurse with specialist skills in asthma, diabetes and chronic obstructive airways disease who attended the practice one day a week.

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 both electronically and by post. We saw that any urgent issues were dealt with by the on call GP and routine information was dealt with by the named GP. Discharge summaries and letters from outpatients were usually seen and acted upon on the day of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We saw an example of where actions had been taken when a discharge summary had been missed to prevent recurrence.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the procedure for taking action on hospital notifications was working well in this respect.

The practice held multidisciplinary team meetings weekly to discuss patients with complex needs. For example, those with long term condition and end of life care needs. These meetings were attended by district nurses, GPs and the AgeUK team and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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 with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and commenced this in April 2015. (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. 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 and their responsibilities 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.

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. Where appropriate we saw that their carers were also involved in this process. These care plans were reviewed annually and had a section stating the patient's preferences for treatment and decisions. All GPs 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).

The practice documented consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery had been followed.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between

Are services effective?

(for example, treatment is effective)

lawful and unlawful restraint. The practice had an electronic panic button on the computer screen also one beneath the reception desk which linked directly to the police.

Health promotion and prevention

The practice used information about the needs of the practice population identified by a variety of sources to help focus health promotion activity.

It was practice policy to offer a health check 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 15 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to patients aged 40 to 75 years. Practice data showed that 56 patients in this age group had taken up the offer of the health check in 2014. Any health concerns identified which required urgent attention were referred to the GP that day.

The practice had many ways of identifying patients who needed additional support and it was pro-active in offering additional help. The health care assistant was trained in

smoking cessation support and advice and had supported 35 patients in 2014 of whom 23 successfully stopped smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 84.8%, which was above the national average of 81.9%. The practice used the national guidance for following up patients who did not attend for their cervical screening test and sent out three recall letters. There was a specific member of staff responsible for this.

Patient with mental health problems were sent appointments for physical health checks and the practice worked with the mental health team to encourage attendance. The practice had 49 patients on the mental health register and had carried out 25 checks but 11 of these were incomplete as patients often would not attend for blood tests required.

The practice offered a full range of immunisations for children which were administered by the health visiting service. Travel and flu vaccinations in line with current national guidance were provided by the practice nurses. For childhood immunisation last year's performance was 87.8% at 12 months which was below the CCG average of 97.8% but was 100% at age two years.

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 national patient survey 2014, and a survey of 45 patients undertaken by the practice in 2015. The practice did not have a patient participation group (PPG), but had representatives from the practice who attended a locality patient group hosted by the CCG, who represented the views of patients at the practice. (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 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 above average for its satisfaction scores on consultations with doctors.

For example:

- 93% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 93% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and the majority were positive about the service experienced. All cards with the exception of one commented on satisfaction with the doctors stating they provided very good care. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. Whilst comments stated they were satisfied with care there were four cards which expressed difficulty in getting an appointment and one commented that the reception staff were not always discreet. Patients commented that staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. Three of them told us they were satisfied with

the care provided by the practice and said their dignity and privacy was respected and the doctors were caring and treated them with kindness but one patient expressed experiencing difficulty in getting an appointment.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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.

The practice reception desk was at a high level which helped keep patient information private. We noted one comment from the comment cards that a patient felt more discretion was needed from reception staff. We observed that the reception desk offered little privacy as conversations between the patient and the receptionist could be overheard.

Eighty-four percent of respondents of the patient survey said they found the receptionists helpful which was comparable to the CCG average of 85% and national average of 87%. This was confirmed during our inspection when we heard a receptionist on the telephone providing a patient with information about how and where to access the health visiting service.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident regarding abusive behaviour to the staff that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed. There was a notice on the reception area stating the practice's zero tolerance for abusive behaviour. However, we noted this was not easily visible as it was on top of the desk.

Care planning and involvement in decisions about care and treatment

Are services caring?

The 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 rated the practice highly in these areas. For example:

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 86% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.

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. For example, we spoke with a very young patient who told us that the GP always involved them in their care and explained everything to them to ensure they understood what was happening to them.

Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see any signs in the practice informing patients of this facility. Staff told us that if they were booking patients for new patient health checks they would offer a translator at the time of making the appointment.

Patient/carer support to cope emotionally with care and treatment

The patient 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:

- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.

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 that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice offered carers health checks opportunistically and provided information and leaflets regarding support organisations available to them. They were also invited to attend for a flu vaccination. We were shown the written information available for carers to ensure they understood the various avenues of support available to them and one of the GPs had received a carers award.

Staff told us that if families had suffered a bereavement, their usual GP would contact them to determine if any further support was necessary and signpost them to relevant support services where required. None of the patients we spoke with had experienced a bereavement since being at the practice.

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 had a significant number of patients with diabetes and the GP had undertaken additional training in this area to help deliver better services to patients in this group. They also employed the services of a practice nurse from another practice with expertise in asthma and diabetes one day per week.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that the GPs attended the locality team meetings alternately but we saw no evidence of formal feedback to the team. However, staff we spoke with appeared to know what was happening in the locality.

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus services offered by the practice such as diabetes care.

The practice had received a limited amount of negative feedback from patients but had addressed areas that had been highlighted and attempted to use other methods to gain more patient views. For example, they had introduced a log book in reception to record any verbal comments or complaints, and had also arranged customer service training to help staff, in response to a difficult patient who had become aggressive. They had also put measures in place to help alleviate dissatisfaction with waiting times by keeping patients informed when doctors were running late. We saw from minutes of the practice meeting that patients complaints had been discussed and actions and solutions suggested and implemented.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice

population were English speaking patients but access to translation services were available if they were needed. However, we noted that this was not advertised to patients in the reception area. Staff were aware of the translation service and told us they would offer this if a new patient was attending for their new patient medical.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. We also noted there was an induction hearing loop to assist patients with hearing difficulties.

Staff told us that they registered patients who were of "no fixed abode" using a hotel address and offered a full range of services for these patients. There was a system for flagging vulnerability in individual patient records.

The partners were male and female GPs and therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning although staff told us they had not accessed this. However, we noted that equality and diversity had been included in all job descriptions stating the requirement to support this and staff demonstrated knowledge of equality and diversity.

Access to the service

The surgery was open from 8.00am until 7.30pm on Mondays and 8.00am until 6.30 Tuesday to Friday. Appointments with the GPs were available from 9am until 11.30am and 2.40pm until 5pm Tuesday to Friday with extended hours appointments from 6.30 until 7.30pm on Mondays to provide better access to those patients who worked. Appointments with nurses were available from 8am. There were on the day appointments and emergency appointments available when patients needed to see a doctor urgently and for patients with sick children.

Comprehensive information was available to patients about appointments on the NHS Choices website and at the surgery. When the practice was closed if patients called

Are services responsive to people's needs?

(for example, to feedback?)

the practice, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP. Home visits were made to a local care home as and when necessary by whichever doctor was on call that day.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well in these areas with the exception of waiting to see their GP once in the surgery. For example:

- 87% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 82% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%.
- 55% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67% and national average of 65%.
- 87% said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.

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 although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking six weeks 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

We saw that 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. They also kept a book in the reception area where they recorded verbal complaints and issues which patients raised which had been kept since September 2014. We noted that many of these issues could have been made formal complaints and prompted learning outcomes or reported as significant events.

We saw that information was available to help patients understand the complaints system but was available only on request and there were no notices in reception to tell patients how to complain or explain the procedure. Patients we spoke with were not aware of the process but told us they would contact the practice manager if they wanted to complain. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months as this was all that had been recorded other than the comments book containing feedback in reception. We saw that the complaints had been followed up but did not see evidence of shared learning from the outcomes such as minutes from team meetings. However, staff were able to give examples where information had been shared and lessons had been learned.

We saw an annual report of complaints but this was for 2013/14. The practice reviewed complaints and comments and looked for trends but we did not see evidence of sharing outcomes with staff or any robust process to follow them up as described in the complaints policy. However, we noted they had taken action such as customer service training to address comments regarding issues with reception staff.

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

Discussions with the GPs and practice manager demonstrated that the practice had a vision to deliver high quality care and promote good outcomes for patients. However, this vision was not documented and there was no evidence of any structured aligned strategy to achieve and sustain this vision and share with the staff. Discussions with the GPs and practice manager showed that they had plans for the practice but we did not see documentary evidence of such plans.

We spoke with six members of staff and they demonstrated a commitment to providing a good service for patients but told us the vision and strategy had been communicated informally. We looked at minutes of the practice meeting which was well attended and contained updates on general practice issues, but no information regarding the direction of 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 desktop of any computer within the practice and we saw a folder containing these was also available for staff. We looked at a selection of these policies and procedures and found that most contained a review date but noted that the Disaster Handling and Continuity Plan had not been dated. All other policies and procedures we looked at had been reviewed annually or every two years and were up to date.

There were two partners and a regular locum providing medical care and one of the partners was the lead for both child and adult safeguarding and attended the locality meeting monthly and another GP was the lead for information governance. Other staff had lead roles, for example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We were not able to speak with the practice nurses on the day of inspection as they were not on duty but spoke with the health care assistant and four members of reception and administrative 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 with any concerns. They told us that the practice worked together closely and talked about issues as they arose and that they felt communication was good.

The practice used the Quality and Outcomes Framework as a means to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards with the exception of diabetes and osteoporosis. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice carried out clinical audits which it used to monitor quality and had systems to identify where action should be taken. For example, an audit of infection rates following minor surgery. The practice recorded significant events and we saw that staff recorded issues, comments and views, that occurred in the practice, which were discussed informally and at practice meetings. Evidence from other data from sources such as complaints was used to identify areas where improvements could be made. Additionally, whilst the practice did not have its own patient participation group, it did have patients who represented the views of patients at the practice, both to the practice and broader CCG group. We saw 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. For example, the practice had started to give out appointment cards in response to patients complaining they had been given the wrong appointment time.

The practice had identified and recorded some risks, but there was no consistent approach to demonstrate that these had been managed. We noted that the systems in place to monitor the quality of the service were inconsistent and did not adequately identify risks and issues with quality and appeared ineffective. For example, the methods for checking expiry dates of medicines and equipment had not identified out of date products. The recruitment procedures had not been robust and DBS checks had not been obtained by the practice for some

Are services well-led?

Requires improvement 

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

nursing staff as they had accepted ones carried out by previous employers. There had also been no DBS checks for the non-clinical staff member who carried out chaperone duties.

The practice held quarterly staff meetings where governance issues were discussed. For example we saw reference in the minutes of meetings to child protection contact details and contractors who may be needed in the event of an emergency.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Staff told us they were involved in discussions with the GPs about the practice but this was more informal. However, they told us that they felt part of the practice and that their input was valued.

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

Seeking and acting on feedback from patients, public and staff

Whilst discussions with the staff at the practice showed they valued feedback from patients, they had been unable to form their own patient participation group (PPG) but had two patients who represented patient views at the local CCG patient meeting. They had carried out their own practice survey, and gained the views of patients in the comments book in reception and through complaints. The practice manager showed us the analysis of the last patient survey, from which we saw that actions had been implemented.

We also saw evidence that the practice had reviewed its' results from the national patient survey to see if there were any areas that needed addressing.

The practice had also gathered feedback from staff through appraisal, staff meetings and informal 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 were undertaking management training and was receiving support from the practice manager. 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 undertake training when they identified a need. The practice nurses carried out general practice nurse duties and we saw from staff records that the nurses had attended training in a range of areas, for example, safeguarding, basic life support and anaphylaxis, diabetes, insulin and wound management. Staff files we looked at showed regular appraisals took place for reception and administration staff but we saw that the practice manager had not had an appraisal since March 2011. The lead GP told us that they carried out appraisal for the nursing staff but we could not see evidence that these had been carried out and the nurses were not on duty to discuss whether this had taken place. The outcomes had not been completed on the staff record and the practice manager was not aware if they had taken place.

The practice had completed reviews of significant events but we noted there were issues in the daily log book in reception that could have been reported formally to demonstrate investigation, improved outcomes and shared learning.

Vision and strategy

Discussions with the GPs and practice manager demonstrated that the practice had a vision to deliver high quality care and promote good outcomes for patients. However, this vision was not documented and there was no evidence of any structured aligned strategy to achieve and sustain this vision and share with the staff. Discussions with the GPs and practice manager showed that they had plans for the practice but we did not see documentary evidence of such plans.

Are services well-led?

Requires improvement 

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

We spoke with six members of staff and they demonstrated a commitment to providing a good service for patients but told us the vision and strategy had been communicated informally. We looked at minutes of the practice meeting which was well attended and contained updates on general practice issues, but no information regarding the direction of 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 desktop of any computer within the practice and we saw a folder containing these was also available for staff. We looked at a selection of these policies and procedures and found that most contained a review date but noted that the Disaster Handling and Continuity Plan had not been dated. All other policies and procedures we looked at had been reviewed annually or every two years and were up to date.

There were two partners and a regular locum providing medical care and one of the partners was the lead for both child and adult safeguarding and attended the locality meeting monthly and another GP was the lead for information governance. Other staff had lead roles, for example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We were not able to speak with the practice nurses on the day of inspection as they were not on duty but spoke with the health care assistant and four members of reception and administrative 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 with any concerns. They told us that the practice worked together closely and talked about issues as they arose and that they felt communication was good.

The practice used the Quality and Outcomes Framework as a means to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards with the exception of diabetes and osteoporosis. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

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The practice had identified and recorded some risks, but there was no consistent approach to demonstrate that these had been managed. We noted that the systems in place to monitor the quality of the service were inconsistent and did not adequately identify risks and issues with quality and appeared ineffective. For example, the methods for checking expiry dates of medicines and equipment had not identified out of date products. The recruitment procedures had not been robust and DBS checks had not been obtained by the practice for some nursing staff as they had accepted ones carried out by previous employers. There had also been no DBS checks for the non-clinical staff member who carried out chaperone duties.

The practice held quarterly staff meetings where governance issues were discussed. For example we saw reference in the minutes of meetings to child protection contact details and contractors who may be needed in the event of an emergency.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find

Are services well-led?

Requires improvement 

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

these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Staff told us they were involved in discussions with the GPs about the practice but this was more informal. However, they told us that they felt part of the practice and that their input was valued.

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

Seeking and acting on feedback from patients, public and staff

Whilst discussions with the staff at the practice showed they valued feedback from patients, they had been unable to form their own patient participation group (PPG) but had two patients who represented patient views at the local CCG patient meeting. They had carried out their own practice survey, and gained the views of patients in the comments book in reception and through complaints. The practice manager showed us the analysis of the last patient survey, from which we saw that actions had been implemented.

We also saw evidence that the practice had reviewed its' results from the national patient survey to see if there were any areas that needed addressing.

The practice had also gathered feedback from staff through appraisal, staff meetings and informal 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 were undertaking management training and was receiving support from the practice manager. 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 undertake training when they identified a need. The practice nurses carried out general practice nurse duties and we saw from staff records that the nurses had attended training in a range of areas, for example, safeguarding, basic life support and anaphylaxis, diabetes, insulin and wound management. Staff files we looked at showed regular appraisals took place for reception and administration staff but we saw that the practice manager had not had an appraisal since March 2011. The lead GP told us that they carried out appraisal for the nursing staff but we could not see evidence that these had been carried out and the nurses were not on duty to discuss whether this had taken place. The outcomes had not been completed on the staff record and the practice manager was not aware if they had taken place.

The practice had completed reviews of significant events but we noted there were issues in the daily log book in reception that could have been reported formally to demonstrate investigation, improved outcomes and shared learning.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: We found the provider did not operate appropriate systems to provide the practice manager and nursing staff with appropriate on-going and periodic supervision and appraisal to make sure their competencies were maintained. Regulation 18 (2) (a)

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 Regulation 17 HSCA (RA) Regulations 2014 Good Governance How the regulation was not being met: We found that the provider did not operate systems and processes that enabled them identify and assess monitor risks to the health and safety and /or welfare of people who used the service including those related to checking of emergency medicines, emergency equipment, prescription security, legionella risk assessments and significant events. We also found that some policies and procedures needed a review. Regulation 17 (2)(a) (b) (d)(i) (f)

Regulated activity	Regulation
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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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

We found that the provider did not operate effective recruitment procedures and had not made the required pre-employment checks specified in schedule 3 of the health and social care act 2008 (regulated activities) regulation 2014, including Disclosure and Barring checks (DBS) on staff that needed this check, identity checks and obtaining references.

Regulation 19 (2)(a) (3)(a)(b)