Somerset Medical centre

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

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 Somerset Medical Centre on 21 July 2015. Overall the practice is rated as inadequate.

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

Our key findings were as follows:

- Patients were at risk of harm because inadequate systems were in place to keep patients safe including those for incident reporting, safeguarding and medicine management.
- There was insufficient clinical staff to keep patients safe and inadequate clinical leadership.
- National patient survey data showed the practice scored below average in terms of access to appointments, access to a preferred GP and several other aspects of care.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

Importantly, the provider must:

- Ensure there is adequate clinical staff employed in the practice and with the appropriate skills to meet the needs of patients and there is adequate clinical leadership within the practice.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform including providing clinical care and treatment in accordance with national guidance and guidelines.
- Review arrangements for storing and accessing emergency equipment / medicines and ensure regular checks are recorded. Provide access to an automated

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external defibrillator (AED) or carry out a risk assessment to assess the risk of not having access to this equipment. Ensure vaccine fridge temperatures are checked daily and recorded.
- Implement robust procedures for identifying, reporting, taking appropriate action and sharing learning from significant events / incidents and ensure safeguarding procedures are robust.
- Introduce a detailed locum induction pack to ensure all locums have adequate information to carry out their roles safely.
- Ensure information received from other service providers is acted on in all instances and robust handover procedures are in place for staff to follow at the end of clinical sessions.
- Implement action plans to improve Quality and Outcomes Framework (QOF) performance and carry out clinical audit to drive improvement in patient outcomes.
- Develop a clear vision for the practice and a strategy to deliver it. Ensure it is shared with staff and staff know their responsibilities in relation to it.
- Ensure all of the practices' policies and procedures are up to date, accurate and staff know where they are located and understand them.

In addition the provider should:

- Provide staff training in equality and diversity.
- Implement measures to improve patient satisfaction in relation to access to appointments / preferred GP, involvement in decisions about care and treatment, consultations with the GPs and nurses and being treated with care and concern by clinical staff.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. Somerset Medical Centre are not to carry out any regulated activities at the location for a period of three months.

On 21 July 2015 we served the practice a Section 31 of the Health and Social Care Act 2008 ("the Act") notice to impose these conditions in relation to their registration as a service provider. This will be for a period of three months. We will inspect the practice again in three months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

Inadequate

The practice is rated as inadequate for providing safe services, as there are areas where improvements must be made. Data showed that patients rated the practice lower than others for many aspects of care. Survey data showed that patients were not always treated with compassion, dignity and respect and not all felt cared for, supported and listened to. Patients were not fully supported to cope emotionally with care and treatment.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. Although NICE and other professional guidance was available to staff it was not discussed amongst the clinical team to improve the standard of care and treatment provided. The practice could not demonstrate improved outcomes for patients through clinical audit. Where QOF performance was below local / national average, action plans were not in place to facilitate improvement. The practice worked with other services however information from other service providers was not always acted on. Staff were not always up to date with training in the specialised areas they practised. Not all staff had regular performance reviews.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services, as there are areas where improvements must be made. Data showed that patients rated the practice lower than others for many aspects of care. Data showed that patients were not always treated with compassion, dignity and respect and not all felt care for, supported and listened to. Patients were not always fully supported to cope emotionally with care and treatment.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services as there are areas where improvements should be made. Feedback from patients reported that access to a preferred GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. Data showed that the practice was rated lower than others for access to appointments and satisfaction with opening hours. 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). The complaints procedure was accessible and easy to understand.

Summary of findings

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and clinical leadership was lacking. The practice had a number of policies and procedures to govern activity, but these were not all up to date and contained inaccurate information. The practice held monthly team meetings however a clinician was not always present. Not all staff had received regular performance reviews and did not have clear objectives.

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

Inadequate

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

The practice had a lower than national average number of older patients. The percentage of over 75 years was 4.3% and over 85 years was 0.9% (National average 7.6% and 2.2% respectively). The practice participated in the integrated care pilot and had identified 177 older patients at risk of unnecessary hospital admission and had completed 37 care plans. Regular multidisciplinary team meetings were held with district nurses, palliative care team, health visitors and community matrons to manage older patients. There was a named GP for older patients and safeguarding vulnerable adults training for all staff. However, the named GP and safeguarding lead was at the practice for only one clinical session a week.

People with long term conditions

Inadequate

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

The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 39.2% and 37.6%. These were lower than the England averages of 54% and 48.8%. Whilst the practices' Quality and Outcomes Framework (QOF) performance in 2014 for the management of some long-term conditions were above the local / national average, performance for diabetes and hypertension indicators was below average and these were conditions with a high prevalence in the local population. There were no action plans in place to improve performance.

Families, children and young people

Inadequate

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

The practice had a higher number of children aged 0 to 4 years compared to the national average (6.6% compared to 6%) and a lower number of children aged 5 to 14 years (8.6% compared to 11.4%). The percentage of children aged under 18 years was lower

Summary of findings

than the national average (11.7% compared to 14.8%). The practice provided services to meet the needs of families, children and young people including childhood immunisations, cervical cytology and a smoking cessation service aimed at this population group. Staff had received training on child protection however safeguarding procedures were not robust. The practices' performance for childhood immunisations in 2014 was overall below the local CCG average. For example, vaccinations given to one year olds ranged from 64.7% to 85.3% (CCG average; 77% to 92.6%), two year olds from 85.7% to 92.9% (CCG average; 86.6% to 100%) and vaccinations for five year olds ranged from 33.3% to 90.5% (CCG average; 73.3% to 94%).

Working age people (including those recently retired and students)

Inadequate

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

The percentage of patients in paid work or full time education was 61.6% which was above the national average of 60.2%. The practice offered extended hours for this population group which provided eight additional appointments a week. The practice provided online access to appointments and repeat prescriptions. A text message reminder system was in place for appointments.

People whose circumstances may make them vulnerable

Inadequate

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

The practice carried out annual reviews of patients with learning disabilities. The practice worked with a local agency for homeless people and register patients under the agencies office. The practice provided open access for travellers, migrants and patients who are unemployed or going through financial difficulties. A GP had a special interest in methadone prescribing for the treatment of substance misuse. However we found that they had not completed formal training and no up to date refresher courses had been undertaken.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate 

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

The practice carried out annual reviews of patients on the mental health register and screened patients for dementia. QOF performance in 2014 for mental health was 69.3%, below the CCG average of 92.1% and the national average of 90.4%.

QOF performance in 2014 for dementia was 100% which was above to the CCG average of 98.7% and the national average 93.4%.

Summary of findings

What people who use the service say

We spoke with nine patients who used the service. We reviewed 17 completed comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 to which 108 patients responded and an improving practice questionnaire (IPQ) completed in December 2014 by an external company, to which 85 patients responded. Evidence from all these sources showed a mixed response in terms of satisfaction with their GP practice. Data from the national patient survey showed the practice scored below average for a number of aspects of care although patients we spoke with and comment cards received where more positive.

Areas for improvement

Action the service MUST take to improve

- Ensure there is adequate clinical staff employed in the practice and with the appropriate skills to meet the needs of patients and there is adequate clinical leadership within the practice.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform including providing clinical care and treatment in accordance with national guidance and guidelines.
- Review arrangements for storing and accessing emergency equipment / medicines and ensure regular checks are recorded. Provide access to an automated external defibrillator (AED) or carry out a risk assessment to assess the risk of not having access to this equipment. Ensure vaccine fridge temperatures are checked daily and recorded.
- Implement robust procedures for identifying, reporting, taking appropriate action and sharing learning from significant events / incidents and ensure safeguarding procedures are robust.
- Introduce a detailed locum induction pack to ensure all locums have adequate information to carry out their roles safely.
- Ensure information received from other service providers is acted on in all instances and robust handover procedures are in place for staff to follow at the end of clinical sessions.
- Implement action plans to improve Quality and Outcomes Framework (QOF) performance and carry out clinical audit to drive improvement in patient outcomes.
- Develop a clear vision for the practice and a strategy to deliver it. Ensure it is shared with staff and staff know their responsibilities in relation to it.
- Ensure all of the practices' policies and procedures are up to date, accurate and staff know where they are located and understand them.

Action the service SHOULD take to improve

- Provide staff training in equality and diversity.
- Implement measures to improve patient satisfaction in relation to access to appointments / preferred GP, involvement in decisions about care and treatment, consultations with the GPs and nurses and being treated with care and concern by clinical staff.

Somerset Medical centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a second CQC inspector, a GP Specialist Advisor and a Practice Manager Specialist Advisor who were granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Somerset Medical centre

Somerset Medical Centre is situated at 64 Somerset Road, Southall, Ealing, UB1 2TS. The practice provides primary medical services through a General Medical Services (GMS) to approximately 2200 patients in Southall (GMS is one of the three contracting routes that have been made available to enable commissioning of primary care services). The practice is part of the NHS Ealing Clinical Commissioning Group (CCG) which comprises 79 GP practices. The ethnicity of the practice population is predominantly of Indian origin with a higher than national average number of patients between 20 and 44 years of age. Life expectancy is 79 years for males and 84 years for females which is in line with national averages. The local area is the fourth most deprived in the London Borough of Ealing (people living in more deprived areas tend to have greater need for health services). The practice has a high number of patients who are migrants including refugees and those in social housing which represent up to half of the practice population.

The practice team consists of a male GP partner (1 session/week) who is the registered manager, a female salaried GP (5 sessions/week), a practice manager, a regular locum GP (3 sessions/week), a practice nurse (10 hours/week), two healthcare assistants, a phlebotomist and a small team of reception/administration staff. There is a second male GP partner whose registration is currently suspended by the General Medical Council (GMC).

As well as providing general medical services, the practice offers the following clinics opportunistically; asthma and allergy, diabetes, hypertension, child health surveillance, vaccines and immunisation, antenatal and family planning.

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, surgical procedures, family planning and maternity and midwifery services.

The practices' opening hours are 08:00 to 18:30 Monday to Friday with extended hours on Mondays and Fridays to 19:15. The practice closes for lunch between 13:00 and 14:00. The practice has opted out of providing out-of-hours services to their own patients and directs patients to out-of-hours providers through the NHS 111 service.

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, and to look at the overall quality of the service.

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 hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 July 2015. During our visit we spoke with a range of staff including one GP, the practice nurse, health care assistant, the practice manager, assistant practice manager, two reception staff and spoke with nine patients who used the service including five members of the Patient Participation Group. We reviewed 17 completed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not prioritise safety and utilise information from reported incidents and national patient safety alerts to identify risks and improve patient safety. The systems in place for the reporting of significant events, incidents and near misses were inadequate. Staff were aware of their responsibilities to raise concerns but they were not always clear on what constituted a serious incident in their practice. For example, minor incidents involving rude or demanding patients were reported as significant events whilst serious incidents including a vaccine fridge failure had not been reported.

We reviewed significant event records since 2007 and found little evidence of a safe track record. Significant events had not been managed consistently over time and so the practice could not show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Procedures for reporting, recording, taking appropriate action and sharing learning from significant event analysis (SEAs) were not robust and some SEAs we reviewed represented situations of high medical risk. Staff were not clear on what constituted an SEA, there was no written policy for staff to reference and limited shared learning through practice meetings. One reported SEA dated August 2014 involved a prescribing error where a patient was prescribed double the permitted dose of a medication. This error was picked up by the pharmacist who informed the practice. The SEA stated that outcomes may have been overdose, but there were no recorded learning points or reflection which supported the seriousness of this error. The outcome only stated that doctors and staff should be more careful, and prescriptions double checked at reception. A second reported SEA dated January 2015 involved a patient who attended with dizziness, the patient deteriorated and became non-communicative. The patient was referred to accident and emergency, however the learning points recorded just stated 'patient education'. We were also made aware of a serious SEA where the vaccine fridge was accidently switched off and the incident had not been reported to the relevant authorities. Another SEA we reviewed stated that a patient attended the practice at 15:35 one afternoon with chest pain requesting a blood pressure check. The patient was told to go to accident and emergency as there was no GP in the practice. The patient refused and waited for the GP to start clinic before eventually agreeing to go to hospital. There was nothing else recorded on the SEA form, no action to prevent recurrence and no learning points or reflection.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults, however they were not robust. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The GPs were trained in child protection to Level 3 and non-clinical staff to Level 1. However the nurse had only received training to Level 1 which was not in line with intercollegiate guidance. All staff had received training in safeguarding vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. However although the contact details of the local safeguarding teams were available, the practice did not have a protocol for staff to follow when referring safeguarding concerns.

The practice manager told us the GP partner who worked one session a week was the appointed lead for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and had completed child protection training to Level 3. However, the GP only attended the practice for up to one day per week and therefore was rarely available to lead on safeguarding issues. We also found the practices' safeguarding policy had not been updated since 2013 and stated that the second GP partner and the salaried GP were the safeguarding leads. Not all staff we spoke with knew who the safeguarding lead was, and who to speak with in the practice if they had a safeguarding concern and not all staff were aware of the safeguarding policy.

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 were chaperone notices visible on the waiting room noticeboard and on consulting room doors (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). All nursing staff, including health care assistants, had been trained to be a chaperone and were able to demonstrate an understanding of the role. Reception staff would act as a chaperone if health care assistants were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be 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 room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had two medicine refrigerators for the storage of vaccines; each fridge had a designated number; one and two. The practice nurse took responsibility for the stock controls with the fridge temperatures being recorded by different staff due to variable work schedules. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. However, when we reviewed the temperature records for fridge one, we found that records were incomplete, there was no evidence of the temperature being recorded from January 2015 to April 2015. Recordings were complete from May to July 2015 until the day of the inspection apart from an omission on the 17 July 2015. We informed the practice manager who could not provide evidence of the missing records.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. We were told that there had been an incident where the vaccine fridge had been unplugged accidently over a weekend. We were told the vaccines had been disposed of but we could not be assured that this was in line with the practices' medicine management policy as there was no written policy in place. We were also told that the event had not been reported to the appropriate authorities including Public Health England and the Care Quality Commission. The practice had no written policy or protocol for the prescribing of methadone or antibiotics and the GP we spoke with stored prescription due dates on her mobile phone. 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 and we saw examples of these which were in date. However there was no authorisation signature from either the practice nurse or clinicians.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves and aprons) was available. Hand gel was available throughout the building and hand washing sinks with soap, gel and hand towel dispensers were available in treatment rooms. The practice had completed an infection control audit on the 17 June 2015 and points for action had been implemented which included increasing the amount of hand gel available in the practice.

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 and staff had received infection control training. It was unclear who the designated lead for infection control was within the practice, however the practice nurse had taken on the role. Clinical waste disposal contracts were in place and spillage kits were available. We saw that clinical waste bins in treatment rooms had labels identifying when they were opened and by whom, with the date recorded. However we found the cupboard where clinical waste bins were stored when full was in the main patient waiting area and there was no secure lock on the door to prevent non practice staff gaining access.

The practice had undertaken a risk assessment for Legionella (a bacterium which can contaminate water systems in buildings) and monthly water temperature checks were being carried out to mitigate risks.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and

displayed stickers indicating the last testing date which was March 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The last calibration date was May 2015.

We spoke with the practice nurse about checking emergency equipment, we saw that the equipment was available but there was no routine system in place to record the checks.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff, and appropriate recruitment checks had been undertaken prior to employment including those for locum staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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).

We were very concerned that there was not enough clinical staff to keep patients safe. The lead GP partner only worked one session a week in this practice because he was based at another practice. Including the lead GP partner there were two part time GPs, a regular locum GP who worked a total of 4.5 days between them and a practice nurse working 10 hours per week. There was only one GP running sessions at the practice at any one time who as well as doing consultations was on call for patients, prescriptions and administration duties. The GP we spoke with told us that often, for example, during lunch or whilst conducting home visits there was no GP on site providing clinical cover. There were different doctors covering the morning and afternoon sessions and the afternoon GP commonly only came to the practice at 16:00. There was no formal handover. Therefore there was inadequate cross cover to ensure patient safety whilst the practice was open. This was also a major concern because of reliance on locums. An example of this was a reported incident we reviewed where we noted that a patient had attended the practice at 15:30 one afternoon with chest pains and requested a blood pressure check. The patient was told by staff to go to accident and emergency as there was no GP at the practice. The patient refused and waited for the GP to start clinic and was sent to hospital. With no clinician on site the delay in the patient been treated put their safety at significant risk.

Locums covered GP and nurse absences. However we found the locum induction pack was incomplete and did not include enough information for locums to work at the practice especially when there were no other GPs on the premises. It did not contain important policies and protocols such as those for antibiotic prescribing and it did not state the location of the keys to access the emergency medicines. Therefore patient safety was at serious risk.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included a health and safety audit carried out in 2015. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice had carried out risk assessments to ensure the environment was safe, however there was no system in place to monitor staffing levels to ensure patients were kept safe.

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 in May 2015. Emergency equipment was available including access to oxygen and staff knew the location of this equipment. The oxygen cylinder was stored in a cupboard with the expiry date displayed, however it was heavy to move around and there were no wheels to transport it. The practice did not have an automated external defibrillator (used in cardiac emergencies) and there was no risk assessment to identify and mitigate the risks of not having access to this equipment. The practice nurse had overall responsibility for ensuring emergency medicines were within date. The contents of the emergency medicines box list was displayed on the inside of the cupboard were the medicines were stored. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Although the emergency medicines we checked were in date, there was no evidence of regular

Inadequate

Are services safe?

checks of the medicines been undertaken and recorded. We also found the keys to access the emergency medicines were stored at reception and therefore the medicines were not readily accessible in an emergency situation.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice including power failure and IT failure. 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 practice had a buddy practice, however not all staff were aware of this.

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 however they had not practised regular fire drills.

Inadequate

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, however it was not clear how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners and therefore could not demonstrate how they kept themselves up to date.

We discussed with a GP how NICE guidance and clinical updates were received into the practice. The GP we spoke with told us these were received electronically and emailed to her by the practice manager, however as she did not meet with the other doctors it was not disseminated further within the practice. There was also no evidence from meeting minutes to demonstrate that NICE guidance was discussed, implications for the practice's performance and patients identified, and required actions agreed.

There was no clinical representative for the practice at Clinical Commissioning Group (CCG) meetings and these were attended by the practice manager only. The GP we spoke with told us that she did not have any time to update herself on the content of these meetings.

The GP partner was the clinical lead for the practice however he was only present at the practice for one clinical session per week and had virtually no contact with the other clinicians. Therefore he could not provide adequate leadership on specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disorder and asthma. All clinical QOF work was left to one part-time GP working five sessions a week, with support from a part time practice nurse.

There were no protocols in place to avoid discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

The practice was unable to show evidence of clinical audits that had been undertaken that demonstrated improved outcomes for patients. We were shown two audits carried out in the previous year. Both audits related to the Clinical commissioning Group (CCG) prescribing incentive scheme. The first was an audit of patients with chronic obstructive pulmonary disorder (COPD) to ensure that prescribing is in line with NICE Guidance and the second was a general audit of patients prescribed repeat medicines. The audits showed one cycle of information gathering with some broad changes to practice, however they were incomplete in that there were no re-audits to measure improved outcomes for patients. In the two audits we reviewed it was stated that the results of the audits were disseminated by the GP partner to the staff via a meeting. However, we found that the GP partner had only attended one clinical meeting in the previous twelve months and the meeting minutes did not support this claim.

There was no evidence of clinical audits linked to safety alerts 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). There was no evidence that clinical audit was routinely used to drive improvements in the quality of patient care. The GP we spoke with told us there was no time to complete audits other than those audits mandated by the CCG medicines management team.

This practice achieved 93.9% of the total QOF target in 2014, which was above the national average of 93.5%. Specific clinical indicators where the practice was above CCG and national averages included:

- The dementia diagnosis rate was 100% which was above to the CCG average of 98.7% and the national average 93.4%
- Performance for asthma QOF indicators was 100% which was above the CCG average of 98.7% and the national average of 97.2%
- Performance for chronic obstructive pulmonary disorder QOF indicators was 100% which was above the CCG average of 96.7% and the national average of 95.2%
- Performance for palliative care QOF indicators was 100% which was above the CCG average of 92.9% and the national average of 96.7%
- Performance for peripheral arterial disease QOF indicators was 100% which was above the CCG average of 93.7% and the national average of 91.2%

The practice was aware of all the areas where performance was not in line with national or CCG figures however action plans setting out how these were being addressed were not in place. Specific examples to demonstrate where the practice were underperforming include:

Inadequate

Are services effective?

(for example, treatment is effective)

- Performance for diabetes QOF indicators was 82.6%, below the CCG average of 87.9% and the national average of 91.1%
- Performance for hypertension QOF indicators was 85.5%, below the CCG average of 91.6% and the national average of 88.4%
- Performance for mental health was 69.3%, below the CCG average of 92.1% and the national average of 90.4%
- Performance for learning disability QOF indicators was 57.1%, below the CCG average of 74.5% and the national of 84%
- Performance for osteoporosis QOF indicators was 66.7%, below the CCG average of 70.3% and the national average of 84.4%

Overall clinical achievement was 91.3% which was below both CCG and national averages. We looked at QOF clinical prevalence figures for the practice and found that diabetes and hypertension had the highest prevalence of all QOF clinical indicators in the practice population (7.74% and 13.87% respectively), however we found there was no plans in place to improve the management of these conditions.

The practice's prescribing rates were similar to expected when compared to national figures. This included the prescribing of antibiotics, non-steroidal anti-inflammatory medicines and hypnotics.

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 outpatient attendance rates were similar to other local practices.

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. We noted that the salaried GP had special interests in methadone prescribing and minor surgery. However we found the GP had not done any formal training in methadone prescribing and no up to date refresher courses had been undertaken. The GP had only ad hoc support from a substance misuse counsellor. In addition the GP had not attended any training in minor surgery in the previous two years to refresh their skills. There was no written protocol in place for following up patients after minor surgery to check for complications or abnormal histology.

The GPs were up to date with their yearly continuing professional development requirements and all 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).

Most staff had undertaken annual appraisals that identified learning and development needs. However we found the practice nurse had not been appraised in the two years she had worked at the practice.

The practice nurse and health care assistants 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, cervical cytology, anticoagulation therapy, smoking cessation, ear care and tissue viability.

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. The practice did not have a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of-hours reports, 111 reports and pathology results were seen by a GP on the day they were received. The GP who saw these documents and results was responsible for the action required, however we found information was not always acted on. The GP we spoke with during our inspection gave us two examples where information had not been acted on in their absence. The first was a urine result showing a patient had a urinary tract infection which was not actioned until the GP returned to work, and the second was where the out-of-hours service had asked the practice to contact a patient diagnosed with a fracture and the request was not acted on.

Inadequate

Are services effective?

(for example, treatment is effective)

Emergency hospital admission rates for the practice were similar to expected when compared to the national average. These included emergency cancer admissions and the number of emergency admissions for 19 ambulatory care sensitive conditions.

The practice held multidisciplinary team meetings monthly. These meetings were attended by district nurses, palliative care nurses, health visitors and the community matrons to discuss patients with complex needs.

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.

The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

We found that the practice did not have a written handover policy or robust procedures that clinicians followed at the end of clinical sessions to ensure important information was received and actioned by the next GP on duty. We were told that reception staff were relied upon to pass on information to GPs, however there was no process in place to check that reception staff had passed on this information. The GP we spoke with said handover information was often handwritten and passed to reception staff, however she did not know if the information was received by the next GP on duty as the GPs often did not see each other.

Consent to care and treatment

We found that staff understood the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The GP and nurse we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

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 an 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).

There was a practice policy for documenting 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.

Health promotion and prevention

The practice had not used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were informed of all health concerns detected and these were followed up. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 2.1% of patients in this age group took up the offer of the health check and the practice had met the CCG target of 2%. The practice had 13 patients on the mental health register and seven patients on the learning disability register, and all these patients had received annual physical health checks. The health care assistant offered smoking cessation advice to patients who smoked and there was evidence of success. For example, out of 21 patients offered advice in the previous year, eight patients had stopped smoking.

The practice's performance for the cervical smears performed in the last five years was 82.8%, which was above the target range of 45-80% set by the CCG. The practice also encouraged its patients to attend national screening programmes for bowel cancer, breast cancer and mammogram screening. Weight checks were completed for patients at risk of obesity and they were referred to weight management programs when appropriate.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance for 2014 was overall below CCG averages for childhood immunisation rates. Vaccinations given to one year olds

Inadequate

Are services effective?

(for example, treatment is effective)

ranged from 64.7% to 85.3% (CCG average; 77% to 92.6%), two year olds from 85.7% to 92.9% (CCG average; 86.6% to 100%) and vaccinations for five year olds ranged from 33.3% to 90.5% (CCG average; 73.3% to 94%).

Inadequate

Are services caring?

Our findings

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 to which 108 patients responded and an improving practice questionnaire (IPQ) completed in December 2014 by an external company, to which 85 patients responded.

The evidence from the national patient survey showed the practice achieved below the CCG and national average for patient satisfaction with their GP practice. For example, data from the national patient survey showed that only 52% of respondents would recommend the practice to someone new in the area compared to the CCG average of 69% and national average of 78%. The practice was also below average for its satisfaction scores on consultations with doctors and nurses. For example:

- 74% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 75% said the GP gave them enough time compared to the CCG average of 80% and national average of 87%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 77% said the nurse was good at listening to them compared to the CCG average of 84% and national average of 91%.
- 82% said the nurse gave them enough time compared to the CCG average of 85% and national average of 92%.

Results from the IPQ survey aligned with these results where the practices' average score for similar areas of patient satisfaction were below benchmark figures.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring and treated them with dignity and respect. We observed throughout the inspection that members of staff were courteous to patients attending at the reception desk. Five comment cards were less positive but there were no common themes to these. We also spoke with nine patients on the day of our inspection most of whom told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Although one patient did say a doctor had not spoken to her in a respectful way and had made what was perceived as a dismissive comment.

Results from the national patient survey showed that 78% found the receptionists helpful, below the CCG average of 81% and national average of 87%. This aligned with the IPQ survey where the practice scored below the benchmark figures for satisfaction with reception staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was a request for a chaperone notice displayed on consultation / treatment room doors.

The practice switchboard was located in the reception area, which was shielded by glass partitions which helped keep patient information private. However the reception area was small and it was difficult to promote privacy in this area. One patient we spoke with told us they would phone the practice if there was something they wished to speak privately about as they could be overheard in the reception area. Additionally the results of the national patient survey showed that the practice scored 78% for the helpfulness of reception staff compared to the CCG average of 81% and national average of 87%. Results from the practice survey showed that patient satisfaction with reception staff and privacy/confidentiality were in the middle 50% of all practices surveyed.

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

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed the practice scored below average in relation to questions about patients' involvement in planning and making decisions about their care and treatment. For example:

- 78% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.

Inadequate

Are services caring?

- 58% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 81%.
- 83% said the nurse they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 90%.
- 74% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 77% and the national average of 85%.

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. Comment cards we received were also positive in these aspects of patient care.

Staff told us that translation services were available for patients who did not have English as a first language. The practice information leaflet and practice website informed patients of the languages spoken in the practice. The service had access to a language service to support those patients where English was not their first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed the practice scored below average in relation to questions about emotional support provided by the practice. For example:

- 65% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 85%.
- 72% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 90%.

Results from the IPQ survey aligned with the national patient survey where the practice's average score for similar areas of patient satisfaction were below benchmark figures.

The patients we spoke with on the day of our inspection and the comment cards were more positive. 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. For example, cancer support and information for carers. Patients were unable to comment on bereavement support offered by the practice as they had never needed it.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice engaged with the local Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised, for example extended opening hours. The practice manager attended monthly CCG meetings however there was no clinical representative for the practice at these meetings.

The practice had not met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area and is used to help focus services offered by practices.

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 PPG had requested more information to educate patients. The practice had acted on this by displaying information on a noticeboard in the waiting area, on the practice website and providing more leaflets. Patients also suggested the session time for the practices' pathology service be extended. The practice responded by increasing the session time by one hour.

The practice participated in the Integrated Care Pilot and had completed 37 care plans for patients over 70 years of age.

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 and older patients. The practice population were of mainly Indian origins and staff spoke a range of languages to cater for them including Urdu, Punjabi, Pashto, Hindi, Gujarati and Tamil. Access to online and telephone translation services were also available if needed. Information in the waiting area was also available in different languages. We did not see evidence of a hearing loop or access to British Sign Languages services for those patients hard of hearing.

The premises had not been specifically designed to meet the needs of people with disabilities and it was in need of an upgrade and general redecoration. There was ramp access at the front door for patients with mobility difficulties, a disabled toilet facility and the consulting rooms were all on the ground floor. However the waiting area was cramped with limited space for wheelchairs and prams. This made movement around the practice more difficult and restricted patients' independence.

The practice manager told us that they had patients who were of "no fixed abode" and worked closely with a local homeless agency to ensure they could access services. We were told that the practice also provided care for asylum seekers, migrants and travellers and promoted an open access policy. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice had not provided equality and diversity training for staff and staff had minimal understanding of equality and diversity issues.

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday with extended hours Mondays and Fridays until 19:15. The surgery was closed between 13:00 to 14:00 for lunch. The patient leaflet stated that appointments were available from 08:00 to 18:30 weekdays by phone, in person or online. However the practice website stated that the phone was answered during lunch break only. There was a text messaging service for appointment reminders.

Information was available to patients about appointments on the practice website and in the patient leaflet including how to arrange 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. If patients called the practice when it was closed, 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. We found no information on how to arrange urgent appointments or telephone consultations.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were 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 those patients who were housebound.

The patient survey information we reviewed showed the practice scored below average in relation to questions about access to appointments. For example:

- 34% with a preferred GP usually got to see or speak to that GP compared to the CCG average of 53% and national average of 60%.
- 71% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 56% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 73%.
- 52% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 53% and national average of 65%.
- 67% said they could get through easily to the surgery by phone compared to the CCG average of 69% and national average of 73%.

Results from the IPQ survey did not align with the national patient survey where the practices' average score for similar areas of patient satisfaction with appointments were above benchmark figures.

The nine patients we spoke with on the day of our inspection were generally satisfied with the appointments system and said it was easy to use. They confirmed that they could see the on duty doctor on the same day if they felt their need was urgent. They also said they could see a GP of choice if they were willing to wait one week.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system including a complaints procedure available at reception. 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 two complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Complaints were discussed in practice meetings and this was confirmed by meeting minutes we reviewed.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice manager told us that the practices' vision was to merge with other local practices and increase the number of services provided. However there was no specific vision to deliver high quality care and promote good outcomes for patients and no strategy to deliver it. Staff members we spoke with did not know the practices vision and values and said they had not been involved in developing them. There was no evidence from practice meetings of discussions relating to the practices' vision and values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer system and as hard copies in a policies folder. However not all staff were aware of where they were located and how to access them. We looked at a number of these policies and procedures and found they were not always up to date. For example, the safeguarding policy had not been updated since 2013 and contained inaccurate information. We also found a number of key policies were missing, such as policies for significant event reporting, referral, methadone prescribing and the management of medicines. Staff were not always aware of key policies, for example the GP we spoke with during our inspection was not aware of the safeguarding policy and where to locate it. The practice had a patient leaflet, updated in March 2015 and also a website, however both contained misleading information as to which GPs were currently active at the practice.

There was a lack of effective leadership. One GP partner was the designated lead for QOF, complaints, significant events, safeguarding children and adults, and confidentiality. He was also the named GP for all patients. However the GP partner was present at the practice for up to one day per week as he was based at another practice, and therefore was not available for most of the week to deal with concerns relating to those areas he led on. He rarely attended practice meetings to inform and update staff of changes and the GP we spoke with said the GP partner had virtually no contact with other staff and never handed over patients or anything else in relation to the practice. There was limited evidence from meeting minutes of discussions and learning around significant events, safeguarding cases, complaints or clinical audit. There was no clear lead for infection control and medicines management and the practice nurse assumed she was responsible for these areas. We spoke with seven members of staff and not all of them were clear about their roles and responsibilities or who to report to with specific concerns.

The GP partner did not take an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective, including using the Quality and Outcomes Framework 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 GP partner was the clinical lead for the practice however he was only present at the practice for one clinical session per week and had virtually no contact with the other clinicians. Therefore he could not provide adequate leadership on specialist clinical areas such as diabetes, heart disease, COPD and asthma. All clinical QOF work was left to one part-time GP with support from the practice nurse. The QOF data for this practice showed it was performing overall in line with national standards although performance was below the CCG/national averages for clinical indicators particularly diabetes and hypertension which had the highest prevalence in the practice population. There was no evidence that QOF data was regularly discussed at monthly meetings or action plans produced to maintain or improve outcomes and QOF.

The practice did not have an on-going programme of clinical audits to monitor quality and systems to identify where action should be taken. Evidence from other data sources, including incidents and complaints was not used to identify areas where improvements could be made.

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 identified, recorded and managed some risks. For example, It had carried out a risk assessment for fire safety and an audit for infection control and where risks had been identified action had been taken.

The practice held monthly staff meetings. We looked at minutes from these meetings and found that performance, quality and risks had not been discussed.

Are services well-led?

Inadequate

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example maternity leave, redundancy and training policies which were in place to support staff. The policies were also available to all staff, in a folder kept at the reception, however not all staff we spoke with knew where to find these policies. The practice had a whistleblowing policy in place, however not all staff we spoke with were aware of the policy and did not know what action to take if they had concerns relating to other staff working at the practice.

Leadership, openness and transparency

One GP partner was under suspension by the GMC and the second was only present at the practice for up to one day per week and therefore there was a lack of visible leadership in the practice. Staff told us that the practice manager was responsible for running the practice and was approachable and always took the time to listen to all members of staff. However clinical leadership was lacking and the running of the practice from a clinical perspective rested on a part time salaried GP working five sessions a week.

We saw from minutes that team meetings were held monthly however clinicians were not always present. We also noted that the GP partner had attended only one meeting in the past year. The GP partner was not leading meetings to update staff and inform them of changes.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), annual surveys and the NHS friends and family test. It had an active PPG with 15 members including representatives from various population groups such as older patients and those of working age and of different nationalities. The PPG had been involved in patient satisfaction surveys and met twice a year. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results from these surveys were available on the practice website. We spoke with five members of the PPG including the chair and they were very positive about the role they played and told us they felt engaged with 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 practice had also gathered feedback from staff through appraisals although not all members of staff had received one.

Management lead through learning and improvement

The practice did not provide sufficient support to staff to maintain their clinical professional development through training and mentoring. The GP we spoke with was not up to date with important training such as methadone prescribing and minor surgery and the practice nurse had not received an appraisal in the two years she had been employed by the practice.

There was limited evidence that the practice completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.