The Woodrow Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Woodrow on 10 November 2014 with a further visit on 2 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, responsive and well led services. It also required improvement for providing services for all of the population groups we looked at. It is rated as good for providing a caring service.

Our key findings were as follows:

- The practice team understood the needs of their local population.
- The team was aware of their responsibilities in respect of safeguarding children and adults and worked closely with other professionals. The practice monitored patients with long term conditions to help them manage their health.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had set up a patient participation group and had acted on requests and suggestions that patients made.
- Staff recruitment procedures at the practice had not ensured that all the required information was obtained for staff working at the practice.
- Suitable arrangements were not in place to protect patients and staff against the risk of infection.
- Recruitment procedures did not ensure that all of the required information was always obtained.
- The provider had not told CQC about changes in ownership of the practice due to a partner leaving or made the required applications to change the registration of the practice.
- The provider did not have robust arrangements for assessing and monitoring the quality of the service at the practice.
- Staff were not aware of the provider's vision or strategy for the future of the practice.

Summary of findings

The areas where the provider must make improvements are:

- Protect patients and staff from the risk of exposure to healthcare associated and other infections by effectively operating systems in accordance with guidance on infection prevention and control from the Department of Health.
- Operate effective recruitment processes and ensure that information required by Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (which replaced Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 on 1 April 2015) is available in respect of all staff employed to work at the practice.
- Ensure that effective arrangements for assessing and monitoring the quality of the service at the practice are in place.

In addition the provider should:

- Make arrangements to ensure that the electricity supply to the medicines fridge is not inadvertently turned off.
- Ensure that all staff at the practice are aware of which members of the team are the leads for specific areas of responsibility such as infection control and safeguarding.
- Ensure that staff do not carry out duties in respect of patient care and treatment outside of the scope of their role, training and competence.
- Develop the whistleblowing policy to include full information for staff in relation to their rights and the routes by which they can raise concerns.
- Introduce a more comprehensive range of clinical audits (and ensure full clinical audit cycles are completed) to monitor performance and contribute to staff learning.
- Update the practice complaints procedure to ensure it is in line with nationally recommended guidance and contractual obligations for GPs in England and ensure that complaints are used to provide opportunities for shared learning for all of the practice team.
- Improve communication so that the staff team are kept well informed about the vision and strategy for the future of the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. We found safe practice in respect of safeguarding arrangements for children known to be at risk and staff understood their responsibilities to raise concerns, and to report incidents and near misses. Recruitment processes did not always include the information required under Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 to ensure the safety of patients. The practice had some processes to protect patients and staff against the risk of healthcare associated and other infections. However, it was not clear who was responsible for infection prevention and control within the practice. The practice had not arranged for a Legionella risk assessment to be carried out.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. We found that patients with a long term condition had appropriate support, however patient outcomes were hard to identify as there was no framework for completed clinical audit cycles to take place. Information about very ill patients or those at end of life was not routinely made available to out of hours and ambulance services to ensure that they received care in accordance with their wishes. Feedback indicated that some patients were concerned about a lack of continuity due to the turnover of GPs at the practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients on how well they were treated was generally very positive particularly in respect of the care received by those with a long term condition. However, we saw confidential personal patient information displayed on a notice board in the waiting room. The practice removed this when we raised it with them.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. The practice team was aware of the needs of its local population and were respectful of patients' diverse needs. They had set up a Patient Participation Group (PPG) to gain the views of patients and make improvements. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Feedback from most patients was that they were usually

Summary of findings

able to get appointments easily. However, some commented that it was not always easy to get through to the practice by telephone or obtain appointments at times. The complaints procedure did not have all the required information in line with nationally recommended guidance and contractual obligations for GPs in England to support patients. The practice did not ensure that complaints were used to provide opportunities for shared learning for all of the practice team.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. The leadership, management and governance arrangements lacked direction and structure. The practice did not have robust arrangements for monitoring the quality of the care and treatment. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy and lacked clear boundaries regarding the scope of their roles and responsibilities. The practice did not hold regular governance meetings involving all members of the team.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. The practice had fewer than half the national average numbers of patients aged 65 or above due to the profile of the local population. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with national averages. Home visits were available for older people when needed. Whilst the practice was providing annual health checks for patients aged 75 and over they had not established a full programme of developing personalised care plans for those with the highest level of need. Information was not routinely made available to out of hours and ambulance services to help ensure that patients at the end of their lives received the care and treatment they wished in the place of their choosing.

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

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The practice had significant numbers of patients with various long term conditions including diabetes and chronic obstructive pulmonary disease (COPD). Data showed that more than half of the practice's patients were living with a long term condition or with a health problem that affected their daily lives. The feedback we received from patients with long term conditions gave a positive picture of the care and support they had experienced. Longer appointments and home visits were available when needed. Clinics were held at the practice one or more times each week for different conditions and patients received annual reviews to check their health and care needs. Patients at greater risk due to long term conditions were prioritised for flu vaccinations. However, patients did not have personalised care plans and some were concerned about their care not being consistent due to frequent changes of GPs at the practice. Information was not routinely made available to out of hours and ambulance services to help ensure that patients at the end of their lives received the care and treatment they wished in the place of their choosing.

Summary of findings

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

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The practice had higher than average numbers of patients aged from birth to 18 years and a significant proportion of families living in disadvantaged circumstances due to social and economic deprivation. There were systems in place to identify and follow up children who lived in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We found examples of joint working with midwives, health visitors and particularly in respect of children and young people who had child protection plans in place. Family planning and baby clinics were held at the practice every week and the practice website provided information about a range of relevant topics relating to children and young people.

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

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The practice had average or slightly higher numbers of working age patients than the national average but was in an area where employment opportunities were limited. The practice offered extended opening hours for appointments two mornings each week and one evening (at its branch surgery). However, a small number of patients commented that they were not always able to obtain appointments and found it difficult to get through of the telephone. Patients could book appointments or order repeat prescriptions online. Health promotion advice was available on the practice website.

Summary of findings

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

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice was situated in an area of high social and economic deprivation. The practice team were aware of the pressures under which many of their patients lived, for example in respect of housing and employment issues. The practice held a register of patients with a learning disability and called them to have annual health checks.

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.

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

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice was situated in an area of high social and economic deprivation and the practice team were aware of the additional pressures of this for patients with mental health needs. Patients experiencing poor mental health received an annual physical health check and data showed that almost all patients had had this during the previous year. A trained counsellor held a weekly clinic at the practice.

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

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 35 Care Quality Commission (CQC) comment cards patients had filled in. On the day of our inspection we spoke with nine patients. Data available from the NHS England GP patient survey showed that the practice scored in the middle range nationally for patient satisfaction with the practice.

Most patients we received comment cards from or spoke with in person were generally positive about their experience of being patients at The Woodrow. They said that staff at the practice respected their privacy, dignity and confidentiality and treated them politely and as individuals. Patients commented that their GP listened to them and explained the care and treatment they needed. We heard from a number of patients with long term health conditions who described receiving the care, treatment and support they needed to help them manage their conditions. Feedback from some patients included concerns about inadequate communication regarding care and treatment decisions and a lack of continuity due to a high turnover of GPs at the practice.

Most patients told us that they were able to get appointments when they needed them whether this was in an emergency or for routine treatment. However, some patients remarked on the difficulty of getting through by telephone and in obtaining appointments that suited them.

Many patients commented that in their experience the practice was always clean and hygienic.

Areas for improvement

Action the service MUST take to improve

- Protect patients and staff from the risk of exposure to healthcare associated and other infections by effectively operating systems in accordance with guidance on infection prevention and control from the Department of Health.
- Operate effective recruitment processes and ensure that information required by Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 is available in respect of all staff employed to work at the practice.
- Ensure that effective arrangements for assessing and monitoring the quality of the service at the practice are in place.

Action the service SHOULD take to improve

- Make arrangements to ensure that the electricity supply to the medicines fridge is not inadvertently turned off.
- Ensure that all staff at the practice are aware of which members of the team are the leads for specific areas of responsibility such as infection control and safeguarding.
- Ensure that staff do not carry out duties in respect of patient care and treatment outside of the scope of their role, training and competence.
- Develop the whistleblowing policy to include full information for staff in relation to their rights and the routes by which they can raise concerns.
- Introduce a more comprehensive range of clinical audits (and ensure full clinical audit cycles are completed) to monitor performance and contribute to staff learning.
- Update the practice complaints procedure to ensure it is in line with nationally recommended guidance and contractual obligations for GPs in England and ensure that complaints are used to provide opportunities for shared learning for all of the practice team.
- Improve communication so that the staff team are kept well informed about the vision and strategy for the future of the practice.

The Woodrow Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience (a person with direct personal experience of using health and care services).

Background to The Woodrow Medical Centre

The Woodrow is in the Worcestershire town of Redditch and has around 4,000 patients. The practice is in an area with high levels of social and economic deprivation. The practice has a higher proportion of patients who are children, young people and adults up to the age of 35 than the national average. They have a much lower than average number of patients who are over 65, particularly in the over 80 age range.

The practice has a branch surgery called Millstream which we did not visit as part of this inspection because we had not received any specific concerns about the branch, including during our discussions with our partners, NHS England and the Redditch and Bromsgrove CCG.

On the day of the inspection there was one male salaried GP working at the practice. Another salaried GP was not at work on the day of the inspection. When we visited the practice on 2 March 2015 we confirmed that there were two GPs both working full time and that the GP partner worked at the practice part time and sometimes did extra sessions to cover for sickness or holidays. The practice has one practice nurse who is an advanced nurse practitioner (a registered nurse who has acquired additional expert knowledge, decision-making skills and clinical competencies for expanded practice) and a health care assistant who is trained to take blood. The clinical team are supported by a full time practice manager, and a team of five part time administrative and reception staff.

The practice has a Personal Medical Services (PMS) contract with NHS England.

The practice informed us that they are a teaching practice providing placements to medical students who have not yet qualified as doctors.

Based on information we gathered as part of our intelligent monitoring systems we had no specific concerns about the practice. Data we reviewed showed that the practice was achieving results that were in line with other practices in England in most areas. However, information obtained from the NHS England Area Team and the Redditch and Bromsgrove Clinical Commissioning Group indicated that there were concerns regarding the leadership of the practice. This was due to the GP partner not working at the practice full time, the frequent changes of GPs at the practice and a lack of clarity regarding their status as salaried GPs or partners.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services which they can access by using the NHS 111 phone number.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS England Area Team and Worcestershire Healthwatch. We carried out an announced visit on 10 November 2014. We sent CQC comment cards to the practice. We received 35 completed cards. These gave us information about those patients' views of the practice. On the day of the inspection we spoke with nine patients at the practice and with a range of staff (a salaried GP, the practice nurse, the practice manager, a healthcare assistant and reception staff).

The Care Quality Commission's records show that the practice has two partners. However, during this inspection we found that the partnership arrangements had changed during 2013 when one of these partners left. Only one of the GPs registered with us as a partner was now at the practice. In this report we have referred to them as 'the GP partner'. The GP partner was away when we inspected the practice on 10 November 2014. We subsequently spoke with them on 17 December 2014 to follow up some information regarding the inspection and registration of the practice. We returned to the practice on 2 March 2015 because there were some specific topics we needed to clarify with the GP partner.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice had a system for reporting, recording and monitoring significant events including a structured reporting form to record the details of individual events. All the staff could use this to report any concerns they identified. When an incident or event was recorded the practice stored the details in a file which was available for staff to refer to. The practice had recorded events over the previous year but had not collated the information to provide an overview of any trends or improvements.

Learning and improvement from safety incidents

We looked at some of the incidents that had taken place and saw that practice staff had identified areas for learning. For example, on one occasion staff had approached some young men who were behaving suspiciously in the practice building. Afterwards the team had identified that the member of staff might have placed themselves at risk and as a result staff had been instructed to call the police in that type of situation. We saw evidence that the incident had been shared openly and discussed at a staff meeting the following day so that staff could learn from the event.

In another situation staff had become concerned about a patient who lived alone. They acted on this and as a result the patient received the medical attention and other support they needed. The 'action to be taken' section of the significant event reporting form highlighted that good communication had played a part in a successful outcome.

Staff we spoke with knew about the process for reporting and recording incidents and some described situations they or other staff had been involved in. These included other situations where there had been concerns about the behaviour of patients which may have put staff or other patients at risk. These staff were aware of policies such as the lone working and violence and aggression policies which were aimed at helping to keep staff safe.

Some staff told us that staff meetings were held as and when needed and that this was usually every other month. A written record was made of the meetings and staff told us that the practice manager discussed these with staff who did not attend. We saw that significant events were discussed at some meetings. The salaried GP told us that if any urgent matters arose such as issues arising from significant events these were discussed informally but were not documented.

National and local safety alerts arrived at the practice by email and the practice manager checked and then circulated these to the GPs, practice nurse and other staff. They saved these on the practice shared drive of the computer system so that there was an audit trail of the information and access to them for reference in the future.

Reliable safety systems and processes including safeguarding

Chaperone presence during appointments was available. The practice had a chaperone policy and we saw there was a copy of this in the waiting room and in one of the GPs' rooms. We saw signs displayed informing patients that this was available. The chaperone role was sometimes carried out by non-clinical staff such as members of the reception team. We saw evidence that these staff had taken part in chaperone training to equip them for this role and staff told us they only carried out this role if they had completed the training.

We saw that the practice had detailed policies and procedures about child and adult safeguarding. These had been reviewed and approved by the GP partner in 2013 and 2014 and had version control information showing that they would be reviewed again during 2015. The policy and procedures contained information about professional responsibilities for safeguarding which was based on national guidance and had been tailored specifically to the practice. We also saw that the contact details for other professionals involved in child and adult safeguarding were included in the procedures and were available for all staff to refer to if necessary. The policies included comprehensive information about types of abuse, how to recognise possible abuse and neglect and scenarios for staff learning. Contact details for key partners within the multi-disciplinary child safeguarding network were clearly displayed in the staff area so that staff could refer to them quickly.

Information about which GP was the safeguarding lead was unclear. Some staff told us that it was the GP partner but other staff told us it was one of the salaried GPs. The salaried GP we spoke with told us that they were the safeguarding lead. They confirmed that they had

completed safeguarding training to enable them to fulfil this role. We saw staff records for non-clinical staff which showed they had completed safeguarding training appropriate to their roles and responsibilities. Some staff had also attended a seminar about domestic violence. The practice nurse told us they had done a safeguarding course the week before the inspection.

Staff we spoke with understood their responsibility to report abuse and neglect. Staff explained that the practice had a significant number of children who had child protection plans in place. The practice had clear systems which made sure that relevant staff were aware of any child who had a protection plan or was in the care of the local authority. The practice took part in a multi-agency child protection meeting every two months, or every month if there were specific concerns.

Some of the staff we spoke with gave us examples of situations where they had needed to make safeguarding referrals. These related to children where practice staff had identified concerns and made referrals to the relevant health and social care professionals so that steps could be taken to ensure the well-being and safety of the patients concerned.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. We noted that the document did not contain contact information for outside bodies such as the General Medical Council (GMC) or CQC if someone wanted to raise a concern about patient safety. The policy wording showed an expectation that staff would raise a concern internally in the first instance. This may not always be possible or appropriate in the event of an employee having serious concerns.

Medicines Management

The prescribing arrangements at the practice gave patients a variety of options for obtaining their repeat prescriptions. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the specific requirements relating to individual medicines. This helped to ensure that patients whose health needed to be monitored had the reviews and checks they needed before repeat prescriptions were issued.

The practice held some prescription pads so that GPs could write a prescription at a patient's home if needed. The practice carried out monthly checks of these so that there was an audit trail of the prescription pads each GP had. The salaried GP confirmed that they collected prescription pads from the practice manager but was not aware of there being a system for recording this.

We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored. The practice nurse was responsible for ordering vaccine stocks and for checking stock and expiry dates. We found that whilst they had an organised system for doing this they had not been keeping a record of the checks they did. The nurse we spoke with understood their responsibilities in respect of national guidance for giving vaccines to patients.

We saw evidence that the fridge used to store vaccines had been re-calibrated and that the next check was due in January 2015. We observed that the fridge had a plug to connect it to the electricity supply; the plug did not have a warning sign to warn staff (including cleaning staff) not to turn the switch off.

Cleanliness & Infection Control

It was unclear who the infection control lead person at the practice was. The practice manager told us this was the practice nurse's role but the practice nurse was not aware that this was her responsibility. We discussed infection prevention and control (IPC) with the practice nurse and with the practice manager. We established from these discussions that the practice did not have a written IPC policy, risk assessment or audit as required in the Code of Practice from the Department of Health on the prevention and control of infections. Similarly, we found that the practice did not have evidence of a legionella risk assessment report. (Legionella is a bacteria found in the environment which can contaminate water systems in buildings).

Some patients who filled in comment cards commented that they were happy with the standards of hygiene and cleanliness at the practice, for example, several mentioned seeing the GPs washing their hands both before and after they did an examination. Some commented that standards of hygiene had improved during the last year. The practice was visibly clean and tidy when we inspected. General cleaning of the premises was done by a housekeeper

employed by the practice. They had checklists to use to record the cleaning they did. Staff told us that any clinical equipment that was not single use was cleaned by the member of the team who had used it.

Cleaning equipment and products were kept secure. Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned. We saw that there was a supply of personal protective equipment, such as disposable gloves and aprons, for staff to use. We saw that the practice used disposable curtains around the treatment couches and that these were labelled to provide a record of the dates when they were last changed.

The practice had a contract with a specialist company for the collection of clinical waste and had locked storage for this and sharps awaiting collection. We saw waste audits carried out by the practice in 2013 and 2014. These were linked to the practice's contract for waste collection and looked at how clinical and other waste was stored and managed at the practice. The audits did not identify any areas for improvement.

There was a sharps injury procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice did not have a system for checking and monitoring that staff immunisations were up to date and had no documentary confirmation available regarding this or the immunity status of staff in respect of Hepatitis B. This meant that the practice did not have evidence that staff were protected against the risk of contracting this virus or that they were not carriers. The records for a member of the clinical team stated that their most recent Hepatitis B check indicated that they should be re-tested. The practice manager was unable to confirm whether or not this had been arranged.

The practice healthcare assistant who had been trained to take blood described their process for preparing their room and equipment for blood test appointments. They explained the process clearly and showed that they understood the importance of robust infection prevention and control systems. They told us about the IPC training they had done. One patient commented about the rigorous hygiene standards of the healthcare assistant when taking blood. This had reassured the patient who had previously lacked confidence in the practice's standards of hygiene for this procedure.

Equipment

From discussions with staff and looking at practice records we established that the practice had the equipment they needed for the care and treatment they provided. We saw evidence that equipment was maintained and re-calibrated as required. Portable electrical equipment was tested and fire safety tests and checks were recorded.

Staffing & Recruitment

The practice had a written recruitment procedure. This did not reflect current legislation or provide details of the checks that the practice would make to ensure the staff they recruited were suitable. In particular it did not contain information about how the practice assessed which staff would require a Disclosure and Barring Service (DBS check) to be carried out. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that the practice had not always carried out DBS checks when either clinical or non-clinical staff were employed to work at the practice. There was no evidence to show how the practice had assessed the different responsibilities and activities of staff to determine if they were eligible for a DBS check and to what level. When we discussed DBS checks with staff they were unclear which staff roles would require a DBS check to be made. We noted that there was no photographic proof of identity for some members of staff.

The staff recruitment records for a member of the clinical team contained no references, employment contract or DBS check. On the day of the inspection the practice was not able to provide confirmation that this clinician's details had been checked to make sure they were registered with the General Medical Council. The practice did this check the day after the inspection and sent us a copy. They also sent us evidence of the clinician's current Medical Defence Union membership and safeguarding training certificates. A DBS check had been requested three days before the inspection. We identified that the GP partner at the practice and the practice nurse had also applied for DBS checks three days before the inspection.

During the inspection on 10 November 2014 we had some concerns about the number of GPs working at the practice because one of the two salaried GPs was away from work and due to leave in leave three weeks.

Requires improvement

Are services safe?

When we spoke with the GP partner on 17 December 2014 they told us that they had secured a replacement salaried GP for seven sessions a week and were available to work some sessions themselves. During our visit on 2 March 2015 we established that there were now two full time GPs and that although one of them was leaving on 1 April a replacement had already been appointed. The replacement GP had begun their induction programme to enable them to become familiar with the practice. The practice had already completed checks of the GMC register, NHS England performers list and had carried out a DBS check.

Several patients commented that they were concerned about the high turnover of GPs. They told us this affected the continuity of their care and also felt that the practice needed more GPs so that a choice would be available. After we spoke with the GP partner on 17 December 2014 they wrote to us to provide explanations regarding the turnover of GPs. They listed six GPs who had left during the previous year and gave explanations regarding the reasons in each case.

Monitoring Safety & Responding to Risk

We saw that risk assessments were available for each room in the practice and for the car park. Adverse events involving safety were discussed so that staff could learn from these.

The practice team explained that because of the location and size of the practice they knew patients well and were aware of those patients who may be at risk, living in difficult circumstances or whose health was of concern. The practice used the computer system to alert GPs and nurses to patients with specific needs which the team might need to be aware of when booking an appointment or seeing a patient. In particular the staff team showed an awareness of patients with mental health needs and of families where children and young people had protection plans in place.

We saw that the practice had a written policy for 'lone working' to help minimise the risks to staff of working on their own whether at the practice, the branch surgery or on visits to patients' homes. There was also a policy about violence and aggression which included guidance to staff about how to avoid confrontation and respond to situations of aggression to reduce the risk of making matters worse. The policy also included information about the rights and responsibilities of patients and staff. The practice had contact details for staff at NHS England Area Team in the event that they considered that a patient should be removed from their patient list and a NHS England Area Team form for recording information about this.

The practice had a policy and procedure entitled 'safe working policy'. This covered several health and safety related topics. These included first aid, electrical equipment, hazardous substances and infection control. Several of these referred staff to more detailed information. A section called 'emergency precautions' related to fire safety; this could reduce staff awareness of its importance for them to read. We noted that this section did not refer staff to a more detailed fire safety policy.

Staff told us that they all took part in moving and handling training.

Arrangements to deal with emergencies and major incidents

The practice had oxygen, an automated external defibrillator (AED) which is a portable electronic device that diagnoses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had emergency medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these medicines monthly to make sure the expiry dates had not passed and that they were available and ready for use when needed.

All staff at the practice completed cardiopulmonary resuscitation (CPR) training every year. They said that this was done at the same time as training updates for using the AED. Staff we spoke with told us that the last training was in June 2014 and took place at the practice.

The practice computer and telephone systems included alert systems for use in emergencies. Staff explained that they could use this in the event of a medical emergency in the building to let colleagues know they needed assistance. One of the staff we spoke with told us that all of the staff knew where the emergency equipment was kept. They told us that if someone was taken ill at the surgery one member of staff would stay with the patient and another would get the equipment.

Requires improvement

Are services safe?

The practice had a business continuity plan to provide the team with essential information and contact details in the event of a significant incident such as the loss of power, other utilities, a computer failure or the need to fully evacuate the premises if there was a fire. The practice did not hold a copy of this off site so that it would always be available even if the building was inaccessible. The practice manager said they would organise this immediately.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the salaried GP and practice nurse showed that that they were aware of and worked to guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. The practice manager received these and circulated them to all the GPs and to the practice nurse. The medical student we spoke with confirmed that they had observed the GPs working in accordance with NICE guidance in respect of depression. They had also seen appropriate management of the treatment of patients with high blood pressure.

Data available to us showed that the practice had mainly mid-range achievement levels for the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. Most of the practice's results were in the mid-range of results compared to national data and some were higher.

The practice had registered an additional 400 patients in 2012 when another practice closed. It had been identified that these patients had increased risk factors for diabetes. This had significantly increased the workload for the practice in respect of managing this long term condition as well as the potential demand for appointments. Nevertheless the practice's QOF results for diabetes were in line with or were better than the average national results.

The healthcare assistant who had been trained to take blood told us that when they saw patients for blood test appointments they checked the patient's records to see whether they were due for any other checks such as having their blood pressure taken.

During the inspection we became aware of a situation in respect of a patient's health. We looked at the medical records for this patient to enable us to check how the person's health had been assessed and how decisions had been made about their treatment. It appeared that the practice had not followed up all aspects of this case. We discussed this with the GP on the day of the inspection and they assured us that they would address this straight away.

Management, monitoring and improving outcomes for people

The practice nurse told us that the GPs would visit patients with long term conditions at home for their routine checks if their mobility and health prevented them from coming in to the practice.

The practice held weekly clinics, some of which were held two or three times a week to monitor the health of patients with long term conditions and help them manage their health. The practice nurse ran the clinics for diabetes, asthma and chronic obstructive airways disease (or COPD, the name for a collection of lung diseases). They also ran a warfarin/anticoagulant clinic three times a week. The healthcare assistant held clinics to take blood twice a week at the main practice and once a week at the branch surgery.

On 10 November 2014 staff we spoke with were unclear about the range of minor surgery carried out at the practice and what the system was for tracking samples and test results. When we visited the practice on 2 March 2015 the GP partner and practice manager confirmed that on occasions procedures were carried out where samples needed to be sent for testing. In urgent situations the practice referred patients to secondary care rather than waiting for their next minor surgery clinic date. We looked at a sample of patient records which assured us that the practice recorded the expected details of minor surgery procedures in patients' electronic records. The practice also showed us a book they used to record when samples were sent for testing. This provided a record of samples being sent for testing and results being returned and dated back several years. Staff did not show us this on 10 November 2014.

When new patients joined the practice the practice manager was responsible for summarising their patient notes so that all of the information about their needs was available on the practice computer system. We found that all of this work was up to date. New patients were asked to fill in a questionnaire about their health and were asked to attend an appointment with the practice nurse for a health check.

The practice did not have a fully established system for completing clinical audit cycles, a process by which a practice demonstrates ongoing quality improvement and effective care. In advance of our inspection, we asked the practice to send us information about clinical audits

Requires improvement

Are services effective?

(for example, treatment is effective)

completed by the practice. They did not send any. We met a medical student on placement at the practice. They told us they had been encouraged to carry out a clinical audit during their placement. They were doing this in respect of the long term use of certain medicines including those used for patients with osteoporosis, a potentially painful and serious condition due to a loss of bone strength. The salaried GP we met with told us they were not aware of any existing work at the practice in respect of clinical audits although they were about to start one in respect of COPD. The GP partner subsequently informed us that the practice was doing this audit because the practice had a high number of patients with COPD compared to national and local prevalence. The plan was to review the age, sex and diagnosis of 130 patients to confirm that the diagnosis had been accurate and treatment appropriate.

On 17 December 2014 we spoke with the GP partner about clinical audits at the practice. They told us that audits did take place. We asked them to send us examples from the past year. They sent us five audit documents. The audits provided data about areas of clinical practice but were not completed cycles.

The practice manager told us there was no lead clinician for care planning. The salaried GP told us that care plans were done by the practice nurse and the healthcare assistant. However, the practice nurse told us they were not involved in care plans. The practice had prioritised care planning for older patients and had completed 132 care plans for this group of patients.

We had comment cards from or spoke with a number of patients who had long term conditions. They gave a positive view of the ongoing care, support and treatment they had received from the GPs and from the practice nurse. A patient gave us an example of the treatment given to a member of their family by one of the GPs who also referred them for specialist care. This had resulted in them recovering well.

Effective staffing

The practice nurse was an advanced nurse practitioner (ANP) and independent prescriber. An ANP is a registered nurse who has acquired additional expert knowledge, decision-making skills and clinical competencies for expanded practice. They had also done extended training in the following specific topics – COPD, asthma, management of patients having blood tests to monitor the levels of anti-clotting medicines they needed, ear irrigation, cervical screening and insulin initiation.

Every GP in England is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England. The GPs at the practice had received the external appraisal necessary to complete the revalidation process. The GP partner confirmed that the salaried GP had their revalidation shortly before the inspection. On 17 December 2014 the GP partner told us their own annual appraisal was due on the following day, 18 December 2014 and their revalidation in February 2015.

We spoke with one of the administrative staff about their induction process when they came to work at the practice. They told us that they were interviewed and started work within one working day. They had received a two hour induction with the practice manager. They described their subsequent training as being 'hands on' and through shadowing other staff.

Some staff had attended a seminar in 2014 about domestic violence and had found this helpful due to the level of domestic violence situations they came across in their work at the practice.

Working with colleagues and other services

The practice told us they worked in partnership with other services such as palliative care nurses from a local hospice who they met with every three months. They told us they experienced great difficulty in meeting with district nurses and had not been able to do so since July 2014 due to the demands on the district nurse service.

The GP we spoke with told us that they used the 'virtual ward' facility regularly to help to avoid patients having to be admitted to hospital. 'Virtual wards' provide hospital led care and treatment direct to patients in their own homes.

One of the administration team told us that they were in the process of reviewing and updating all important contact numbers that the practice team might need.

Information Sharing

Requires improvement

Are services effective?

(for example, treatment is effective)

Staff described their process for making referrals to other health services. GPs gave referral letters to a specific member of the administration team to type and send out. This member of staff showed us that they had a book in which they recorded the details of all referrals. They used this to make sure that they sent all letters out promptly and to monitor whether patients had received their appointments. They told us that they planned to make improvements to the system. This included being more proactive about following up referrals to find out the outcomes because they had only been doing this when patients asked them to check.

Staff told us that all blood test and other test results were seen each morning by the GP who had requested them. If a GP was not at work the practice manager or deputy checked them initially and sent them to the GP working that day. The deputy practice manager used the computer system to monitor this. We looked at the information on the system and saw that the flow of work was up to date. The advanced nurse practitioner told us they also checked blood results and that if they had any doubts about results they would refer these to one of the GPs to check.

The practice had a system for checking, recording and storing information sent to them by other health professionals including the out of hours service. However, the salaried GP confirmed that the practice did not have a system for making information available to the out of hours and ambulance services about patients with complex care needs, such as those receiving end of life care. This, together with the absence of patient care plans could result in patients not having their wishes regarding their care and treatment fulfilled.

Patients confirmed that the practice kept them up to date about test results and contacted them promptly if they needed to come in to see the GP or practice nurse about these.

The practice website contained information for patients about access to patient information and the circumstances in which the practice might share information with other health professionals.

Consent to care and treatment

In situations where people lack capacity to make some decisions through illness or disability, health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA) to ensure that decisions about care and treatment are made in people's best interests.

The practice had a written policy about the MCA. This included information about the principles of the MCA to help clinicians to assess a patient's capacity to be involved or not in decisions about their care and treatment. The policy provided clear guidance about how health professionals should meet the requirements of the MCA including the involvement of Independent Mental Capacity Advocates (IMCAs) and how to approach making best interest decisions with others when patients did not have capacity.

The practice nurse had completed MCA training five years ago and was able to describe the steps they took when assessing the ability of a patient in making informed decisions about their care and treatment. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. A healthcare assistant said they did not have a full understanding of the MCA. However, when we spoke with them about how they would make sure a person was able to give informed consent and what they would do if not, they were able to explain this clearly.

The salaried GP gave us an example of how they had given consideration to the MCA when balancing the risks and benefits to a patient in relation to their preferred options for their care and support at home.

The medical student we met told us that patients' verbal consent was obtained for them to be present during a consultation but this was not supported by written consent.

Health Promotion & Prevention

The practice had an informative website and information leaflets about various health and care topics in the waiting room and reception where patients could see them. The GPs and other staff also had access to information they could print for patients direct from the NHS computer system. This helped to ensure patients always received the most up to date information which could be printed in languages other than English if needed. There was a screen

Requires improvement

Are services effective?

(for example, treatment is effective)

in the waiting room which provided rolling information about a wide range of health conditions. We noticed that the small screen and low sound level made it difficult for the information to be seen and heard.

The practice website and information leaflet contained the names and contact details of organisations providing advice and guidance about a range of subjects related to health and care. These included organisations providing support for people with long term conditions, people with mental health needs or those living in vulnerable circumstances and carers. The website also provided information for young people about sexual health using links to NHS information.

The practice provided flu vaccinations for patients known to be at risk if they developed flu or were for example carers of patients who may be at risk. A patient told us that the practice nurse had telephoned them to remind them to come for their vaccination and why this was important to their health. The practice website contained information about how patients could arrange their appointment for this.

The practice website listed a range of clinics available for patients together with named details of the clinic lead and the specific day the clinic was held. The clinics listed were, well person checks, diabetes, asthma and COPD, warfarin/ anticoagulant, family planning, cervical screening, baby clinic, travel clinic, phlebotomy (taking blood for blood tests) and flu vaccinations.

The practice provided annual health checks for people with learning disabilities, mental health needs and monitored the care needs of patients with long term conditions. This work was reflected in their results for the Quality and Outcome Standards Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. In some areas the practice had achieved results that were better than the national average. These included their reported prevalence of COPD and the percentage of patients with diabetes who had had their flu vaccinations which for 2013/14 was 100%. The practice highlighted to us that they had had a significant increase in work related to patients with diabetes when they accepted 400 new patients from a closing practice who had been identified as being more likely to have this condition.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We received 35 completed comment cards from patients. During the inspection we met and spoke with nine patients. The information we gathered gave us a positive view of the care and treatment patients felt they received. Information we had from the NHS England GP Patient Survey for the period from July 2013 to March 2014 showed that the practice was within the mid-range for patient satisfaction in a range of areas although some scores were at the lower end of the results. Information from the comment cards told us that patients found the staff team to be caring, sensitive to their needs and respectful. Patients described reception staff as patient, kind and welcoming. One person gave an example of a member of staff being rude and uncaring when they had been to the practice for a recent appointment but said that this was not their usual experience.

Patients told us that staff at the practice respected their privacy, dignity and confidentiality. Patients told us that staff always knocked on the door if they came in during an appointment and that their dignity and privacy for intimate examinations was always carefully protected by the staff. Most patients confirmed they did not hear staff discussing patients where others might hear them. However, one patient told us that they had overheard a conversation in reception regarding another patient's medicines and had heard all the details about this.

A notice board in the waiting room was used to display thank you notes and cards from patients and their families. We saw that some of these contained significant confidential personal information about patients including addresses, phone numbers and details of medical conditions. It was clear that these had only been intended for the GP or nurses' eyes, not for public display and it was a concern that staff at the practice had not recognised this. We raised this with the practice and staff removed them before the end of the inspection.

Care planning and involvement in decisions about care and treatment

Many of the patients who gave us information told us they had been patients at the practice for many years and had always felt well supported and cared for. In some cases patients indicated that they had longstanding or complex care needs and that the GPs and other staff had listened to them and responded to their individual needs in a caring way. Most patients told us that the GPs and the practice explained things to them in a way they were able to understand. They said that they could have a conversation with either the GP or the practice nurse and ask questions without feeling anxious about this.

Information leaflets were available in the reception area and the GPs and nurses had access to up to date information from NHS sources to give print outs to patients at their appointments.

Patient/carer support to cope emotionally with care and treatment

We observed that there was little information in the waiting room about organisations specialising in providing bereavement support. However, staff said they knew patients and their families and would contact patients when they needed support. The information contained in the comment cards showed that patients felt supported by the practice. One patient specifically commented on the care and support they had received from the practice following a bereavement. A patient we spoke with told us about one of the GPs visiting a bereaved family to provide support.

We observed that there was little information in the waiting room about support and advice which would be helpful for people with long term or life threatening conditions and for carers. However, a number of patients described being well supported by the practice team and individual GPs and other staff. In addition we found that more information was available on the practice website.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice team were very aware of the needs of the population served by the practice and wanted to provide a service that responded to those needs. The practice had a register of people with mental health support and care needs. Each person on the register was invited for an annual review of their overall health. The practice recognised the particular challenges of accessing GP services for people with learning disabilities and had a learning disability register.

Information from patients suggested that most felt that the practice listened to them and responded well to their needs. Some patients commented that the frequent changes of GPs at the practice concerned them because of the lack of continuity this caused.

The practice had established a patient participation group (PPG) and had introduced a number of improvements at the request of PPG members. These included online prescription ordering and appointment booking and text message appointment reminders as well as redecorating the waiting room to make it more pleasant. (A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients).

Tackling inequity and promoting equality

All of the consulting rooms were on the ground floor and there was level access for patients coming into the building. There was a large free car park which provided accessible parking spaces near to the entrance. The practice had accessible toilet facilities to help people with mobility difficulties and baby changing facilities. There was no alarm call in the toilet if someone needed to call for help.

Staff told us that the practice would be supportive to homeless people who came to the practice to be seen but were not aware of seeing any homeless people in recent times. At the time of our inspection, the practice was not providing medical care to any gypsy or traveller families but confirmed that they had in the past and would do so if any were staying in their catchment area.

The practice had patients from a number of ethnic backgrounds and not all of their patients were able to converse with ease in English. Some members of the practice team spoke several languages and the practice used a telephone interpreting service. We noted that information leaflets in the practice were only available in English. However, GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. The practice website had a facility which patients could use to translate the information provided into a large range of different languages.

The practice had an induction loop to assist people who used hearing aids. The practice website stated that RNID (Royal National Institute for the Deaf) Typetalk was available to assist people with hearing problems when using the telephone and that a signing service was also available.

Access to the service

Staff told us that the GPs visited patients at home if their health and mobility prevented them from coming to the practice for their appointments. This was the case for acute health problems and for patients with long term conditions whose health needed to be monitored.

The practice was open from Monday to Friday. Patients could book appointments by telephone, online or in person. Patients were able to book appointments for the same day or in advance. The practice website stated that appointments could be booked up to four weeks in advance. When we looked at the practice appointment system on the computer we saw that the rota was available for the following three weeks. On 2 March 2015 the practice manager explained that they had been able to increase that to four weeks by securing details of locum availability further ahead.

The practice had appointments available from 7.30am on Mondays and Tuesdays to assist patients who found it difficult to get to the practice later in the day (patients out at work for example) and up until 6pm each evening except Wednesdays. Extended hours were available at the branch surgery, Millstream until 7pm on Tuesdays.

The practice had responded to the PPG report in March 2014 regarding access and had an action plan for

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

improving telephone access and the availability of appointments. This included the introduction of online appointment booking and text message appointment reminders.

Six patients made negative comments either about waiting times to be seen, being able to get through on the telephone or about getting appointments when they needed them. This was particularly highlighted as difficult for patients at work during the day. Others told us that they were able to get appointments readily and some with complex needs or small children were particularly positive about the ease of obtaining appointments, especially when this was urgent. Positive comments were made about the patience of staff when dealing with high volumes of telephone calls and several patients mentioned that they felt this aspect of the service had improved during the last year.

Staff told us that patients telephoning out of hours received a recorded message providing them with details of out of hours arrangements. The practice website stated that the practice provided emergency cover but did not explain the details about this.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. Their complaints policy did not fully meet recognised guidance and contractual obligations for GPs in England because no information was provided about advocacy services or how patients or their supporters could contact the relevant ombudsman if needed. However, the information did provide details about how to contact the CCG.

We looked in detail at two complaints. We saw that in both cases the practice manager had written promptly to the complainant. In the first we saw evidence of the action taken by the practice, a non-defensive response and an apology to the patient concerned. In the second instance the practice manager also wrote promptly to the complainant to acknowledge their concerns. In this instance there was no information to show that the concerns had been actively followed up by the practice and no record of the practice contacting the patient again with the outcome. Whilst patients had received constructive initial responses from the practice there was no evidence that the GP partner and staff had discussed these complaints so that they could all learn from the outcomes.

The practice was unable to provide us with information to show how they dealt with verbal or less formal complaints.

A patient described a situation to us that had led to them making a complaint. They told us they had received an apology but considered that the practice needed to improve communication and be clearer with patients about the plans for treatment and referrals.

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

We spoke with the GP partner on 17 December 2014 and they told us that their vision was to build the practice and to establish a more settled group of GPs. They explained that most of the GPs who had left the practice during the previous year had done so for unavoidable reasons over which the practice had no influence.

When we met the GP partner at the practice on 2 March 2015 they provided us with information regarding their vision for the future of the practice. This included developing the knowledge and skills of all members of the team.

Governance Arrangements

During this inspection we identified a number of areas where the practice needed to make improvements. We were concerned that the practice's own management and systems had not identified these and that the practice had not taken action to make improvements. For example, personal patient information clearly intended to only be seen by practice staff was displayed on a public notice board where anyone could read it. The practice removed this information when we pointed it out to them but this was an example of something that should not have happened. Other examples included staff recruitment procedures and infection control arrangements.

Staff could refer to a range of written policies and procedures to assist them in the management of the practice. These were stored on the practice computer system and were available for all members of the staff team to access and refer to. The policies were 'version controlled' so that the date of past and future reviews were recorded together with the name of the member of staff responsible for this.

We found that there was a lack of clarity regarding the roles and responsibilities of key members of the team. For example staff gave us different information about which member of the team was the lead for infection prevention and control. Some staff believed this to be the practice nurse's role while others thought it was the practice manager or did not know. Similarly some staff believed that the GP partner was the lead for safeguarding while others told us this was the salaried GP's role.

During the inspection we learned from members of staff that some non-clinical staff were occasionally involved in aspects of direct patient care. This included nebulising patients with respiratory difficulty at the practice and passing instruments to a GP during minor surgery. We acknowledged that staff were being caring and helpful but were concerned that they may be acting outside the scope of their role and training. During our discussions with the GP partner on 17 December and when we visited the practice on 2 March we sought further clarification about this.

The GP partner and practice manager explained that staff had only been involved in nebulising patients with full monitoring from a GP or the practice nurse. However, this had included placing the face mask on patients and turning the nebuliser on. This had therefore involved staff in delivering the medicine in the nebuliser to the patient and went beyond providing support. The GP partner assured us that this would not happen again. With regard to the involvement in minor surgery described by staff, the GP partner assured us that non-clinical staff had only carried out "simple tasks" such as moving trolleys and tying aprons. They told us that this no longer took place. These issues indicated that there was a need for the provider to clarify staff roles and responsibilities at the practice.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. 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 e.g. diabetes and implementing preventative measures. The results are published annually. However, there were no structured mechanisms for discussions about these within the staff team.

Leadership, openness and transparency

The Care Quality Commission's records show that the practice has two partners. However during this inspection we found that the partnership arrangements had changed during 2013 when one of these partners left. We also found that the practice website named two other people as partners at the practice who we were not aware of. The GP

Are services well-led?

Requires improvement

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

partner had not told CQC about these changes or made the required applications to change the registration of the practice. We are in contact with the practice separately regarding these registration issues.

Some staff told us that meetings were held as and when needed and that this was usually every other month. A written record was made of the meetings and staff told us that the practice manager discussed these with staff who did not attend. The salaried GP told us that if any urgent matters arose such as issues arising from significant events these were discussed informally but were not documented.

Practice seeks and acts on feedback from users, public and staff

The practice had established a patient participation group (PPG) and we spoke with the newly chosen chair for the group. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. They told us that the practice always listened to the PPG and made changes that members of the group suggested. The chair told us that the practice and the PPG were trying to attract more members and to broaden the representation across age, gender and ethnic groups. They informed us that meetings took place every two to three months and that they advertised these in the practice, on the practice website and in a local pharmacy. They gave us two examples of changes the practice had made in response to PPG suggestions. The telephone number had been changed from a high charge number to a local number so costs to patients were reduced and the waiting room had been redecorated which had made it more inviting. We saw the practice's action plan following a patient survey during 2014. This showed that in response to patients' requests the practice had introduced an online prescription service, an online appointment booking service and text message appointment reminders.

The minutes of a staff meeting for administrative staff in October 2014 showed that the practice manager had informed the team about the introduction of the Family and Friends Test at the practice. This is a national NHS patient survey initiative.

There were also comments slips in reception for patients to use if they wanted to give feedback.

Management lead through learning & improvement

The practice team had an annual practice day when they did cardio pulmonary resuscitation (CPR or basic life support) training and held a full practice meeting.

The practice nurse told us that they received annual supervision from the GP partner. They said that their most recent supervision had been two months ago. They told us that they had not received formal training at the practice but had attended a GP update day with the GP partner and also attended an annual training update at the University of Worcester.

On the day of the inspection we found that the practice did not have a comprehensive range of completed clinical audits cycles to monitor performance and contribute to staff learning. On 17 December 2014 we spoke with the GP partner about clinical audits completed at the practice to demonstrate improved outcomes for patients. They told us that audits did take place. We asked them to send us examples from the past year. They sent us five documents; however these did not provide evidence of completed clinical audit cycles used to improve patient outcomes or provide learning opportunities for the practice team.

The practice was a teaching practice which provided placements for medical students who had not yet qualified as doctors. The practice had one student on placement at the time we did this inspection. They told us that they were in their second week of an eight week block at the practice and were there for two days a week. They said they had mostly been observing but had also done some supervised consultations. They described spending time with the partner and two salaried GPs and observing how information about consultations was entered in patient notes.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients and staff were not protected from the risk of exposure to healthcare associated infections because the provider did not have effective systems in place. In particular there was no infection prevention and control policy or audits, were no adequate systems to protect against the risks associated with legionella and hepatitis B and a lack of clarity about which member of the team was the IPC lead. This was in breach of regulation 12(1) (a),(b),(c) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Patients were not protected because the provider did not have effective recruitment procedures to reduce the potential for unsuitable people gaining employment. This was in breach of regulation 21 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

The provider was not protecting patients and others against the risks of unsafe or inappropriate care and treatment because they were not regularly assessing and monitoring the quality of the service provided at the practice and identifying areas for improvement in a timely way.

This was in breach of Regulation 10(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) and (2) (a) and (b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.