

Village Medical Practice

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Village Medical Practice on 26th June 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, and well led services. It also required improvement for providing services for the population groups older people, people with long term conditions, families, children and young people, working age people including those recently retired and students, vulnerable people and people experiencing poor mental health including dementia. We found the practice was good for providing caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and monitored.

- Risks to patients were assessed with the exception of those relating to recruitment checks.
- Data showed patient outcomes were average for the locality. Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Data showed the practice was rated better than the locality or national average for patient satisfaction.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Accurate patient records were not kept.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were available on the day they were requested.
- The practice did not hold regular governance meetings.

The areas where the provider must make improvements are:

Summary of findings

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure the safeguarding lead is appropriately qualified and trained to undertake the role.
- Ensure all patient records are accurate, up to date and kept securely.
- Ensure information is accessed by a uniquely identifiable computer log in.
- Ensure legionella risk assessments and checks are carried out.
- Have a clear vision for the future of the practice.
- Have appropriate plans in place to deal with a long term absence of the GP.
- Be proactive in ensuring immunisation of the patients for protection against infectious disease.
- Have an automated external defibrillator (AED) at the practice.
- Check medicine fridge temperatures in accordance with the practice policy.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

In addition the provider should:

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Minutes of meetings were kept but these were not detailed enough to know what information was discussed amongst staff

Recruitment checks were not fully completed and there were no records of Disclosure and Barring Service checks on staff having been carried out.

Patient records were not written and managed in way that ensured they were accurate, complete and stored securely. Locums had shared computer access so it was unclear who accessed what record and when.

Records were not being consistently recorded and separate information was kept on paper and on the computer system.

Requires improvement



Are services effective?

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

Data showed patient outcomes were at or below average for the locality. Knowledge of and reference to national guidelines was inconsistent. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes.

Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Patients said they found it easy to make an appointment with the GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led.

It had a vision and a strategy. However, the practice was led by one GP and there were no detailed plans as to what would happen if the GP was to go on leave for an extended period.

There was a leadership structure and staff felt supported by management but at times they weren't sure what the future of the practice would be.

The practice had a number of policies and procedures to govern activity, but some of these were not always followed. Management meetings were held every month.

The practice proactively sought feedback from patients and had been actively recruiting patients for its patient participation group (PPG). All staff had received inductions but not all staff had attended staff meetings.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

Over 75s are monitored and reviewed to help prevent unplanned admissions. There was a care plan in place for every patient who may be at risk of an unplanned admission.

Extended appointments are available to every patient on request. The flu and shingles vaccination are offered to all patients who need one.

Requires improvement



People with long term conditions

Specialist clinics are run for patients with long term conditions such as diabetes, asthma, and chronic heart disease. All patients are reminded to have an annual health check and these are followed up with phone calls. Patient attendance is minimised where possible by arranging other tests or reviews at the same time. This is covered by having longer appointments in these circumstances.

Some patients are managed by secondary care such as those with parkinsons or alzheimers.

Requires improvement



Families, children and young people

The practice nurse gives childhood immunisations in accordance with national guidance. Arrangements with other practices are in place to carry out baby checks.

Same day appointments are always offered to children.

Requires improvement



Working age people (including those recently retired and students)

Extended hours appointments are offered to the working age population. The practice nurse also offers extended hours appointments.

Requires improvement



People whose circumstances may make them vulnerable

Vulnerable patients are identified and health visitors are contacted prior to each clinical meeting to ascertain if there are any other concerns. All vulnerable patients are reviewed at each monthly clinical meeting.

Requires improvement



People experiencing poor mental health (including people with dementia)

All patients with dementia or poor mental health are referred to the local mental health team. The practice reviews any requests from the local mental health team. All patients receive an annual check up and all patients are reviewed by the GP at appointments.

Requires improvement



Summary of findings

What people who use the service say

We spoke with five patients, reviewed 11 comment cards and looked at data from the national patient survey. All of the feedback showed patients were very happy with the care they received from the practice. Patients were able to get an appointment at a time that suited them and usually on the same day. On the day urgent appointments were always available for patients who needed them.

Patients told us the GP was genuinely interested in their health and overall wellbeing and they would have no hesitation in recommending the practice to friends and family.

Areas for improvement

Action the service **MUST** take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure the safeguarding lead is appropriately qualified and trained to undertake the role.
- Ensure all patient records are accurate, up to date and kept securely.
- Ensure legionella risk assessments and checks are carried out.

Action the service **SHOULD** take to improve

- Have a clear vision for the future of the practice.
- Have appropriate plans in place to deal with a long term absence of the GP.
- Be proactive in ensuring immunisation of the patients for protection against infectious disease.
- Should have an automated external defibrillator (aed) at the practice.

Village Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included another CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Village Medical Practice

The Village Medical Practice is a small practice serving the health needs of approximately 1950 patients of which there is a fairly even split between male and females.

The practice team consists of two GP partners. One GP is a non-practicing partner who is not involved in the day to day running of the practice. The other GP partner has been there over 25 years and works nine out of the ten weekly sessions available. There is one practice nurse and a health care assistant.

The practice operates a GMS contract and is supported by an administration and reception team and the practice manager.

The practice is located at:

164 Station Road, West Moors, Ferndown, Dorset, BH22 0JB

The opening hours are Monday to Friday 830am to 1pm. and 2pm to 630pm There is extended opening to 730pm on Mondays.

Out of hours services are provided for patients by using the NHS 111 service. There is level access to the building, wide doors to allow for wheelchair access and good access to consultation rooms. Accessible toilets are available throughout the building.

The practice has a clear and easy to follow website and patients can arrange appointments and repeat prescriptions online.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits.

We also reviewed the practice website and looked at information posted on NHS Choices.

During our visit we spoke with a range of staff which included the GP, nursing and other clinical staff, receptionists, administrators, secretaries and the practice

Detailed findings

manager. We also spoke with five patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice before and during our visit.

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 include:

- 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)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw a record of an incident where a sample had not been received by the laboratory. Since that incident new methods of recording and logging samples received had been introduced and staff given additional training in the correct procedures for handling samples.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last two years and saw this system was followed appropriately. Significant events was not a standing item on the monthly practice meeting agenda but a dedicated meeting was held annually to review actions from past significant events and complaints. The GP explained they would discuss any issues with the relevant team members as and when necessary rather than monthly. Staff we spoke with confirmed this happened but there was no written evidence of this. There was evidence that the practice had learned from incidents and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent the completed forms to the practice manager. We tracked two incidents and saw records were completed in a comprehensive and manner. We saw evidence of action taken as a result and that the learning had been shared. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again. One example was in relation to a medication request by a hospital and the GP noticed this was the wrong medication for the patient.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had identified concerns around safeguarding knowledge and training of key members of staff and carried out an audit of the safeguarding practices in March and April 2015. It identified the lack of certified level 3 safeguarding training for the GP and knowledge of the new policies.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The safeguarding adults policy had been reviewed in December 2014 and further updated in June 2015 to include new contact and legislation details. There was an up to date contact list and safeguarding incident report form. All of the staff we spoke with knew about the updated policy and how to access it.

The safeguarding children policy had been reviewed and updated in March 2015 to include new contact details. All of the staff we spoke with knew about the updates and how to access the policy.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They told us they had been trained in both adult and child safeguarding and although they could explain how to identify vulnerable adults and children they were unable to provide evidence of up to date training to level three requirements.

All staff we spoke with were aware who the lead for safeguarding was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's records. This included information to make staff

Are services safe?

aware of any relevant issues when patients attended appointments, for example children who had been placed on the at risk register by social services. The GP explained that he knows all of his patients and would be able to easily identify any concerns. We did see an up to date list of the vulnerable patients registered at the practice. This was displayed in the staff room on the ground floor. The practice occasionally worked with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We did not see records that 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). There was also no risk assessment for when to carry out DBS checks.

The practice did have a whistleblowing policy that had been reviewed in November 2014 and, with the exception of the GP, all of the staff we spoke with said they were aware of the contents of the policy and would feel comfortable raising any concerns.

Patients individual records were not managed in a way that kept them safe. The GP used a combination of written and computerised records for each patient. However, we found the information was not recorded in a consistent manner. Some information was kept on the written file and other information was stored on the computer system. All of the patient's notes were not accessible in one place. Staff who worked at the practice were aware of this but a locum would not know other information was available.

We found the GP did not use the computer system to record details of patient consultations, results and notes and preferred to hand write everything. Patient records were not fully accurate or complete as other staff including the nurses stored records of patient contact on the computer system. A locum or other member of staff would have to look at the computer and also the written records

to get an overall picture of a patient. If the GP had to go on an extended period of leave then locums could not rely on the information on the computer being accurate and up to date.

We also saw that patient records were not stored securely. They were kept in a shelving unit behind the main reception desk and were not able to be locked away. The practice was aware of this issue, and had recorded this as a risk, and we saw evidence they had obtained quotes for installing a system for locking paper records away.

We also found the locum staff did not have separate log in details for the computer system. They used a shared password.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

Records showed fridge temperature checks were not being carried out consistently and staff could not assure themselves that the medicine fridges were operating correctly on all of the days the practice was open. The practice policy was to check and record fridge temperatures on the days the practice was open. The records showed that on the days the fridges had been checked the minimum and maximum temperatures, for the correct storage of medicines, had not been exceeded.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Are services safe?

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. (Include example found here).

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. The practice had clear systems in place to monitor the prescribing of controlled drugs. They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines were given all the relevant information they required.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in April 2015. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy, specifically in the handling and disposal of clinical waste. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We did not see evidence a risk assessment for legionella testing had been carried out in order to decide that the risk was sufficiently low to make formal testing unnecessary.

The practice had clinical waste management guidelines that had been reviewed in May 2015. Staff were aware of the correct procedures for the handling and disposal of clinical waste and we found it was securely stored. The practice kept clinical waste consignment notes in accordance with the waste regulations.

The practice employed a cleaning contractor and there was a cleaning manual in place and cleaning audits had been carried out to ensure the cleaning was to an appropriate standard.

Are services safe?

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 January 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 medicine fridges.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that some recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body. However we saw that references were not always asked for and it was unclear if appropriate checks through the Disclosure and Barring Service had taken place. (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). The practice was unable to confirm who had a DBS check in place and who had not.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

The practice rarely used the services of a locum GP and used an online locum organisation when needed. We found that appropriate checks of locum GPs were not always undertaken. For example there were no checks on suitability of qualifications.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. 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.

Identified risks were included on a risk log. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We saw an example of actions that had been put in place to reduce identified risks. This included the regular maintenance of fixtures and fittings. Minutes we reviewed showed risks were sometimes discussed within the team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and emergency medicines. The practice did not have an automated external defibrillator (aed) which is used in cardiac emergencies. The resuscitation council states that GP practices should have an aed.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather and access to the building. The document

Are services safe?

also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in 2015.

The practice had carried out a full fire risk assessment in 2006 but had reviewed this on an annual basis with the last review carried out in January 2015. These reviews included actions required to maintain fire safety. The practice had identified areas for improvement and

produced a timetable as to when these improvements should be made by. For example we saw that monthly fire alarm tests had been carried out and that plans to install fire alarm call points on the first floor had been made.

Fire exits were clear and correctly signed and illuminated. However, we found one fire escape door was a patio style door and was locked with the key kept on a notice board. This may have prevented patients and staff from using this exit in an emergency. There was also a step down from this exit and those with mobility issues may have had difficulty in using the exit.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. The GP told us they kept up to date personally but there was no formal system for sharing with other team members. They explained they disseminated relevant information to staff as and when necessary. We saw minutes of meetings which showed this was sometimes discussed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out patient assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on certain conditions. The practice nurse monitored patients with diabetes, hypertension, chronic heart disease and asthma. The administration team arranged the appointments for the patients and this included having blood tests done by the health care assistant. The GP then reviewed the results and made any necessary medication changes by asking the patient to come in and discuss them. The nurse then reviewed the treatment needs accordingly with the patient.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP told us he supported staff who wanted to review and discuss new best practice guidelines, for example, the management of respiratory disorders.

The practice used the knowledge of the GP to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up within three days to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to improve.

The GP explained they undertook clinical audits and had completed a clinical audit cycle as part of their revalidation process in 2014. However, they were unable to produce any written documentation on the audits they told us they had undertaken.

The GP told us clinical audits were often linked to medicines management information, 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).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national)

Are services effective?

(for example, treatment is effective)

clinical targets, It achieved 89% of the total QOF target in 2014 (496 points out of 535), which was below the national average of 96%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse compared to the national average but better than the CCG average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- Performance for mental health related QOF indicators was significantly worse compared to the national average.
- The dementia diagnosis rate was comparable to the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was making use of staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice also kept a register of patients identified as being at high risk of admission to hospital and structured annual reviews were undertaken for people with long term conditions such as diabetes, asthma and COPD.

The practice was not aware of how they compared to other practices in the area.

Effective staffing

Practice staffing included nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses such as annual basic life support. However, the practice manager was able to show a comprehensive online training program for staff.

The GP had good clinical knowledge and additional qualifications such including Batchelors degrees in Science, Medicine, Surgery and Obstetrics.

The GP was up to date with their yearly continuing professional development requirements and had been revalidated in 2014. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had either received or had a date for an annual appraisal that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one member of staff had recently passed their dispensing course.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. Those with extended roles such as seeing patients with long-term conditions including asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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 had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising by these communications. Out-of hours reports, 111 reports and pathology results were all seen and acted on by the GP on the day they were received. Discharge summaries and letters from outpatients were reviewed and acted on

Are services effective?

(for example, treatment is effective)

within three days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were similar to expected at 20.6 per 1,000 of the population compared to the national average of 13.6 per 1,000. The practice discussed admissions avoidance and they used a specialised district nurse, employed by the local NHS trust, who was able to visit patients who may be at risk of admission. The practice monitored A&E attendances and discussed these with the patients during their next consultation.

Information sharing

The practice used several systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had also signed up to the electronic Summary Care Record and had advised patients what this was. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was further information on the practice website which also gave patients an opportunity to opt out of the scheme if they wished.

The practice had systems to provide staff with the information they needed. Staff used electronic and written patient records to coordinate, document and manage patients' care. All staff were fully trained on the system. However, the GP did not use the computer system and other staff used the system to input clinical data. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an

issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions., for example, their preferred place of care.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted the GP to used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled. The GP explained they would usually phone them or arrange an appointment for them.

The practice's performance for the cervical screening programme was 78%, which was similar to the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was below average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 63%, and at risk groups 33%. These were below national averages. The GP explained patients were offered the flu vaccination but did not want it.

- Childhood immunisation rates for the vaccinations given to under twos ranged from 85% to 90% and five year olds from 71% to 85%. These were below CCG and National averages. However, the practice only had seven eligible children registered between the age of 12 months and five years of age.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (put in date of survey), a survey of 41 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also average or above average for its satisfaction scores on consultations with the GP and nurse. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 98% said they were able to get an appointment to see or speak to somebody the last time they tried compared to the CCG average of 90% and national average of 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and all of them were extremely positive about the service experienced. Patients said they felt the practice always offered an excellent service and staff were efficient, helpful and very caring. They said staff treated them with dignity and respect at all times. We also spoke with four patients on the day of our inspection. All of them told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected at all times.

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

rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by partitions which helped keep patient information private. Additionally, 96% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. This was where confidential papers and records were left by the GP in a patients home. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed and new systems put in place to prevent this from happening again.

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 patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 90% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.

Are services caring?

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

Staff told us that none of the registered patients required translation services but they were available for new patients who did not have English as a first language. We saw notices informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it very well in this area. For example:

- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately at all times and helped and provided support when required.

Notices in the patient waiting room and on the patient website told patients how to access a number of support groups and organisations. The GP was aware if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. There was a dedicated carers noticeboard in the waiting area. This information was also available on the practice website. Examples of this information were local transport charities, age UK and advocacy services. There was an extensive list of help and support available on the website as well. Reception staff helped patients access this information if needed.

Staff told us that if families had suffered a bereavement, the GP contacted or visited them. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice undertook well man and well woman clinics to monitor the health and well being of its patients. These were undertaken by the nurse who passed details on to the GP if any risks were identified.

The GP explained they do not actively engage with the local clinical commissioning group as no locum is provided. They read the minutes of the meetings of the locality commission group to stay up to date with local needs and development.

The practice is run by one GP and they had extensive personal knowledge of every patient.

The practice had extended hours opening on Mondays to meet the needs of its working population.

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 or complex needs. The whole of the practice population were English speaking patients but access to telephone translation services was available if needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

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

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

There was a male GP in the practice. They explained this had not been an issue in 30 years of working at the practice. Patients we spoke with told us they felt very comfortable seeing the same GP all the time and they could also see the female nurse if they wished. There was a chaperone available but patients very rarely requested this.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals.

Access to the service

The practice was open from 830am to 1pm and 2pm to 630pm Monday to Friday. Appointments were available Monday 9am to 1130am and 430pm to 730pm, Tuesday 9am to 1130am and 330pm to 5pm, Wednesday 9am to 1130am and 430pm to 630pm, Thursday 9am to 1130am, Friday 9am to 1130am and 430pm to 630pm. Lunchtime is between 1pm and 2pm and during these times the GP undertook any home visits that were necessary.

Patients explained that they could always get an appointment at a time that was convenient to them. Patients confirmed they were normally seen on the same day.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. 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.

Longer appointments were available for all patients who needed one. This also included appointments with a named GP or nurse. Home visits were made those patients who needed one.

Are services responsive to people's needs?

(for example, to feedback?)

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 88% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 92% described their experience of making an appointment as good compared to the CCG average of 82% and national average of 74%.
- 78% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.
- 98% said they could get through easily to the practice by phone compared to the CCG average of 85% and national average of 74%.

Patients we spoke with were very happy with the appointments system and said it was easy to use. They confirmed that they could see the GP on the same day if they felt their need was urgent. Routine appointments were available for booking in advance. Comments received also showed that patients had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. 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. This was included posters displayed around the practice, complaints procedure leaflet and further details supplied through the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. There was openness and transparency with the patient when dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. All of the staff we spoke with knew, understood and shared this vision.

The non-practicing partner resigned the day before the inspection was carried out. The GP explained that he had plans to gradually reduce his workload and eventually retire. However, they were now unsure as to what their, and the practice's future would be.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff within the practice. We looked at five of these policies and procedures and all staff we spoke with had working knowledge of them. All five policies and procedures we looked at had been reviewed annually and were up to date.

There was a structure in the practice with named members of staff in lead roles. For example, there was a practice nurse lead for infection control and the GP was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities.

The practice manager took 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. This included using the Quality and Outcomes Framework (QOF) to measure its performance. However, the QOF data for this practice showed it was performing just below national standards.

Evidence from other data from sources, including incidents and complaints was 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 did not identify, record and manage all risks. Such for the management of patient records, recruitment, training and health and safety. There was a lack of governance arrangement for clinical audits. There were

some risks managed, for example the practice identified there were no fire alarm call points on the first floor and had made arrangements to install these the next time the fire alarm was serviced.

The practice held monthly meetings where governance issues were discussed but significant events were only reviewed annually. We looked at minutes from these meetings and found that performance, quality and risks had not always been recorded as having been discussed.

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

Leadership, openness and transparency

The GP was the visible lead in the practice and staff told us they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice. The GP explained they had taken a silent partner on board back in 2010. With only one GP working at the practice it was unclear what would happen if the GP needed to go on an extended period of leave, however they had used locums when required.

We found that some staff were unaware of the future of the practice.

We saw from minutes that management meetings were held every month. Staff told us that there was an open culture within the practice and they felt supported. Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and

Are services well-led?

Requires improvement 

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

complaints received. The practice was actively recruiting patients to join the PPG and we saw expression of interest forms that gave patients a choice of how much they wanted to be involved.

The practice manager showed us the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice actively sought feedback through comments and feedback forms and encouraged patients to complete the NHS friends and family test. All of the patients we spoke with told us they would not hesitate to recommend the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around dispensing and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through online training. We looked at five staff files and saw that regular appraisals took place. Staff told us that the practice was supportive of training.

The GP told us they are motivated by patient contact and they keep a reflective diary that was used to help learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 (2)

The safeguarding lead did not have certified safeguarding training that was relevant or at a suitable level for their role.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(c)

The provider did not maintain securely, accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Information held on the computer system was not accessed by a uniquely identifiable computer access log in.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

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

Regulation 19 (2) recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in regulation 19(1)(a)

The provider had not completed disclosure and barring service checks on staff.

This section is primarily information for the provider

Requirement notices

The provider did not have robust processes to gather all available information to confirm that persons employed are of good character.

The provider had not ensured staff were suitably qualified before taking up unsupervised roles.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The provider did not have a system in place for carrying out regular audits of the service provided.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12(2)(a) Assessing the risks to the health and safety of service users.

The provider did not have a risk assessment for the premises for the testing of Legionella.