Wivenhoe Surgery

Quality Report

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

Summary of findings

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Overall summary

Wivenhoe surgery provides primary medical and minor injury services to approximately 8300 patients living in the Wivenhoe and Arlesford areas of Essex. Five GP partners are supported by a nursing team and administrative staff. The practice also provides training for medical students.

We found that the practice was caring. Patients' diverse needs were considered and action taken to meet them. Vulnerable patients, such as those with mental health needs and children, were protected from abuse because the practice had effective arrangements in place that reflected best practice.

We found that the services offered to older people and their carers were safe, caring and effective.

Care and treatment was provided to patients in line with nationally recognised clinical guidelines, particularly in relation to long term medical conditions, health screening, vaccination and end of life care. However, clinical effectiveness was not discussed, managed or monitored systematically.

The practice had arrangements in place to inform people of the services available and provided convenient appointment times.

The arrangements in place to ensure that staff were appropriately supported to fulfil their roles were not fully effective.

The practice's systems to monitor the quality and safety of the service and thus drive improvement were inadequate. This included a lack of arrangements to systematically consider the views of patients and staff.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were required to ensure the service was safe.

Patients told us that they felt that they received safe care and treatment.

Many risks associated with delivering the service were effectively managed. However, we found that some risks were not being identified, monitored or addressed by the practice proactively, or systematically.

There were established arrangements to protect patients from the risk of acquiring infections. However, the risks of infection and the use of items beyond their manufacturer's expiry date were not being adequately monitored.

There were staff recruitment procedures in place and there was an appropriate number of skilled clinical and non-clinical staff employed to deliver the service consistently. However, not all staff files contained documentary evidence of pre-employment checks. Staff had not all received training intended to support the safe operation of the service.

Medicines were managed safely and emergency equipment was checked and accessible. Arrangements were in place to ensure business continuity during periods of fluctuating demand for the service and in the event of an emergency. There was a risk that staff may not have been able to access the information to ensure these arrangements were carried out.

The practice had effective arrangements in place to protect vulnerable patients from the risk of harm. Safeguarding policies and procedures for both children and vulnerable adults enabled staff to recognise and act on concerns about abuse.

Whilst adverse incidents were recorded and investigated, we saw limited evidence of the sharing of learning from incidents with staff to ensure improvements were made and reduce the risk of similar events occurring in the future.

Are services effective?

Improvements were required to ensure the service was effective.

Summary of findings

Clinical practice, including consent and prescribing, was delivered in accordance with nationally recognised best practice in primary care. However, clinical effectiveness was not discussed or managed systematically at practice level. Clinical audit was not planned and prioritised and clinical practice was not proactively monitored.

Clinical staff were appropriately qualified and had some opportunities to develop their skills and knowledge. Internal clinical learning events had lapsed due to GPs' capacity and clinical supervision of nurses was not in place.

The practice positively engaged and worked in partnership with a range of other services to meet the needs of patients in a coordinated and effective way.

Patients had access to a variety of health promotion information and services that promoted a healthy lifestyle. Their health needs were assessed promptly and routinely reviewed.

Are services caring?

The service was caring.

Patients and carers described the service positively. Most told us that they were involved in decisions about their care and treatment and that they were treated with dignity and respect by all staff.

Patients' diverse needs were considered and action was taken to meet them.

Patients' confidentiality was effectively protected by staff.

Arrangements were in place to make chaperones available when required. However it was unclear whether chaperones were being used in line with the practice's policy.

A patient survey undertaken in 2013 showed that people felt the doctors and nurses at the practice treated them with care and respect.

Patients were routinely asked for their consent to care and treatment. We saw that where patients did not have the capacity to consent, clinicians acted in accordance with recommended best practice.

Are services responsive to people's needs?

The service was responsive to people's needs.

We found that the practice understood the individual needs of patients and made reasonable adjustments accordingly.

Staff made effective use of electronic systems to communicate with their patients.

Summary of findings

The practice had arrangements in place to ensure that it could meet patient needs with minimal delay. Arrangements for appointments were regularly reviewed to ensure that patients could access the services they required in line with best practice.

The practice's arrangements ensured that patients' complaints were dealt with promptly and effectively. However, the practice's policy did not reflect best practice guidance and the learning from complaints was not systematically shared to drive improvement.

Are services well-led?

Improvements were required to ensure the practice was well-led.

There was a well-defined leadership and management structure, and areas of responsibility for each GP partner were clear. However, development of the practice was not informed by individual, team or organisational objectives, or an overall plan.

Some of the practice's policies and procedures were not implemented fully or consistently. This had a negative impact on the training and appraisal of staff and the use of audit and regular safety checks.

The practice did not demonstrate that they understood the need to systematically consider patients' experiences.

Some routine checks to monitor the safety of the service were not being either completed or recorded effectively.

We saw some positive outcomes from clinical audit; however audits were not prioritised or coordinated effectively.

Some staff did not feel well supported and valued. They told us they were not consulted about the running of the practice and did not feel able to influence improvement.

The practice level arrangements to ensure continuous quality improvement were unclear. The practice did not ensure that staff learned from quality indicators, including patient feedback, audit, complaints and incidents.

Summary of findings

The six population groups and what we found

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

Older people

The practice had considered the safety of their older patients and made reasonable adjustments to support those patients with limited mobility to access the practice. Effective arrangements were in place to protect older people from abuse.

Older patients (and their families) were supported to understand and make decisions about their health, care and treatment, including at the end of their lives. Carers were identified and offered support.

Older patients were supported by the practice to ensure that the care and treatment they received was in line with national guidance.

The arrangements for access to the practice ensured that the individual needs of older patients, including those who were housebound or bereaved, were met.

People with long-term conditions

Patients who had common long-term medical conditions received care and treatment from the practice according to national guidelines.

There was no overall plan for audit to ensure that the management of all long term conditions was reviewed.

Staff, including those visiting the practice, had the appropriate skills to meet their needs.

Carers of patients who had long term conditions were being identified by the practice and provided with appropriate support.

The practice worked effectively with community health and social care services, such as community matrons, to support patients whose needs were complex.

The arrangements for access to the service ensured that the individual needs of patients with long term conditions, including those who were housebound, were met.

Mothers, babies, children and young people

Patients aged up to 19 years made up 15.5% of the practice population.

Mothers, babies, children and young people were protected from abuse because the practice had effective arrangements in place that reflected best practice.

Summary of findings

Although some risks were well managed, the practice did not always identify and address risks associated with the delivery of the service.

Patients and carers described the service positively and told us that they had good access to appointments.

Screening and vaccination programmes were delivered in line with national guidance. However, the checks on stocks of vaccines were not recorded to provide assurance of their availability and suitability for use.

The working-age population and those recently retired

Patients of working age had access to screening programmes in line with national guidance.

It was not clear whether appointment times were sufficiently flexible to accommodate patients who were in full-time employment. However, we did not see any complaints relating to availability of appointments and no patients we spoke with offered criticism about recent service changes.

People in vulnerable circumstances who may have poor access to primary care

The practice population was not diverse and patients were able to request to be seen by a clinician of their preferred gender.

Vulnerable patients were protected from abuse because the practice had effective arrangements in place that reflected best practice.

Staff from three support services for people with a learning disability told us that they had developed good working relationships with the practice. They described the service they received and the practice staff positively, emphasising the practice's responsiveness to their clients' needs.

Care and treatment was provided in line with nationally recognised clinical guidelines, particularly in relation to end of life care.

People experiencing poor mental health

Patients experiencing poor mental health were protected from abuse because the practice had effective arrangements in place that reflected best practice.

Effective and timely referrals were made for patients who required specialist psychological counselling and treatment, or support and advice.

Staff obtained consent from patients in line with national guidance. They were aware of the need to assess a patient's mental capacity to give informed consent, particularly in relation to mental health.

Summary of findings

What people who use the service say

The 18 patients (or their carers/relatives) we spoke with during our inspection told us that they felt safe at the practice. They said that they felt that they received safe care and treatment. For example, staff supporting vulnerable patients in the community told us that they received a prompt response to urgent requests for care and treatment, such as when a patient contracted an infection.

Most patients told us that they could usually obtain an appointment to see a doctor or nurse of their choice when they required one. One parent told us that they had reasonable access to appointments for their children, although fitting them in around school hours could sometimes be challenging.

We received mixed views from the patients we spoke with about general cleanliness at the practice and poor standards of cleanliness had also been the subject of two separate complaints received by the practice and the Care Quality Commission respectively. Most patients said that they thought the practice was clean. However, one described the premises as shabby.

Patients and carers described the practice and staff very positively. They told us that staff were responsive to their health needs and referred them on to other services appropriately. A parent described to us how effectively a GP had built a rapport with their child during a consultation. One patient talked about how they had been recalled for regular check-ups for diabetes at nurse-led clinics.

A national patient survey undertaken in 2013 showed that people felt the doctors and nurses at the practice treated them with care and respect. Most of the feedback we received from patients was complimentary about practice staff, saying that they were polite and caring. Most respondents to the 2013 patient survey and staff from local services supporting patients with a learning disability made positive comments in relation to the helpfulness of staff. They said that when they requested information about care or treatment, they always spoke with an appropriate person who understood their query.

All of the patients we spoke with told us that they did not have any concerns about the confidentiality of their information. One patient told us that they used to be asked about the reason they were requesting an appointment, but this practice had ceased.

We received varying responses from patients about their experience of being involved in decisions about their care. Two patients told us that they did not feel they had adequate time with, or explanation from, the clinician who had seen them. They said that appointments were sometimes rushed. The remaining patients told us that doctors and nurses gave full and adequate explanations and allowed them time to ask questions about their care and treatment.

Staff supporting patients with a learning disability in the community told us that they had developed good working relationships with the practice. They said that clinical and administrative staff understood their clients' needs and responded well to requests for a clinician's input, or telephone advice. They described how clinicians acted in individual patients' best interests and considered their views. They said that practice staff understood that patients with autism needed to access services in a different way.

Not all of the patients we spoke knew how to make a complaint.

Areas for improvement

Action the service MUST take to improve

Proactive monitoring must systematically support continuous service improvement. The practice must ensure that their systems to regularly assess and monitor the quality and safety of service that people receive are effective. Service improvement must be better informed by collecting and considering the views of patients and staff.

The practice's arrangements to ensure that all practice staff are appropriately supported to fulfil their roles must

Summary of findings

be improved. The practice's training programme and appraisals must support the safe operation of the service and be completed by all staff. All nursing staff must receive regular clinical supervision.

Action the service COULD take to improve

The strategic direction and development of the practice could be better supported by an overall plan that is shared with staff. This plan should be informed by individual, team or organisational objectives that reflect an up to date practice mission statement.

Service quality and safety could be enhanced by the facilitation of internal clinical learning, team building or group training events to ensure staff awareness of best practice.

The risks to patients could be more effectively assessed and managed, in relation to confidentiality, pre-employment checks on staff, the impact of service changes and the management of emergency equipment.

The availability of the practice's emergency contingency plan to all staff could be improved to ensure that they can respond to emergencies affecting business continuity.

The practice's complaints policy could better reflect nationally recognised best practice guidance and ensure that complaints are responded to in a timely way.

The management of incidents could be better supported by a policy or procedure to ensure that they are consistently identified and reported by staff.

Wivenhoe Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a second CQC inspector and a practice manager.

Background to Wivenhoe Surgery

This five GP partner practice serves approximately 8300 people who live in Wivenhoe and Arlesford. It is housed in a small building with limited space. There are plans in place for the practice to move to new premises in the future to enable them to further develop the practice and the services it provides.

Wivenhoe Surgery is one of the higher achieving practices in North East Essex in relation to the Quality and Outcomes Framework, which are national indicators for general practice. The patient population does not contain significant groups of vulnerable people. The exception being that the practice serves six small services that provide support to 25 people who have a learning disability.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

We carried out an announced inspection on 3 June 2014. The inspection team consisted of two care Quality commission inspectors, a GP and a practice manager, who provided specialist advice. The regulated activities we inspected were 'diagnostic and screening procedures; family planning; surgical procedures; maternity and midwifery services and treatment of diseases, disorder or injury'.

Before visiting, we reviewed a range of information, including performance data, which we held about the practice. We asked other organisations to share what they knew about the practice. We spoke with staff from three services that supported patients with learning disabilities in their own homes. We also spoke with a local pharmacist that dispensed medicines for practice patients. We carried out an announced visit on 3 June 2014. During our visit we spoke with 11 staff, including the practice manager, GPs, the nursing team, reception and administrative staff. We also spoke with 18 patients and their carers or family members who were using the service. We observed how people were spoken with. We reviewed information from patients and members of the public who had shared their views and experiences of the service.

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

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

Detailed findings

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Are services safe?

Summary of findings

Improvements were required to ensure the service was safe.

Patients told us that they felt that they received safe care and treatment.

Many risks associated with delivering the service were effectively managed. However, we found that some risks were not being identified, monitored or addressed by the practice proactively, or systematically.

There were established arrangements to protect patients from the risk of acquiring infections. However, the risks of infection and the use of items beyond their manufacturer's expiry date were not being adequately monitored.

There were staff recruitment procedures in place and there was an appropriate number of skilled clinical and non-clinical staff employed to deliver the service consistently. However, not all staff files contained documentary evidence of pre-employment checks. Staff had not all received training intended to support the safe operation of the service.

Medicines were managed safely and emergency equipment was checked and accessible. Arrangements were in place to ensure business continuity during periods of fluctuating demand for the service and in the event of an emergency. There was a risk that staff may not have been able to access the information to ensure these arrangements were not carried out.

The practice had effective arrangements in place to protect vulnerable patients from the risk of harm. Safeguarding policies and procedures for both children and vulnerable adults enabled staff to recognise and act on concerns about abuse.

Whilst adverse incidents were recorded and investigated, we saw limited evidence of the sharing of learning from incidents with staff to ensure improvements were made and reduce the risk of similar events occurring in the future.

Our findings

Safe patient care

There were reporting systems in place to promote the recording and investigation of incidents and accidents. We looked at accident records and a sample of eight recorded incidents that had occurred during the year preceding our inspection. The reporting of incidents was not supported by a policy or procedure. However, the staff we spoke with told us that they could raise any concerns they may have, or report incidents to their immediate manager so that the practice was aware of risks to staff or patients.

The practice had a process in place for recruiting staff to work at the practice. Disclosure and Barring Service (DBS) checks were undertaken for all staff to ensure their suitability to work with patients and confidential personal information. The practice manager demonstrated that they took a rational risk-based approach about when to obtain DBS checks on new staff. Routine checks were also undertaken on the professional registration of clinical staff to ensure their fitness to practice. However, we looked at a sample of three staff files and found that they were poorly organised and did not contain all of the evidence we would expect to see in relation to pre-employment checks. For example, we found gaps in recording that references had been sought when two staff were recruited.

The 18 patients (or their carers/relatives) we spoke with during our inspection told us that they felt safe at the practice. For example, staff supporting vulnerable patients in the community told us that they received a prompt response to urgent requests for care and treatment, such as when a patient contracted an infection.

Learning from incidents

The practice took an open and transparent approach to handling incidents or near misses. We found that the majority of incidents had been recorded in full and we were able to track them through reporting and investigation to outcome recommendations. The information recorded about two different incidents involving incorrect medication being given to patients did not enable us to properly understand whether initial action had been taken to ensure that the patients involved were properly informed. However, records of six other incidents showed that the circumstances had been discussed with those patients involved.

Are services safe?

We found some evidence that improvements had been made in response to incidents. For example, following a relevant incident the template for recording the insertion and removal of a contraceptive coil had been reviewed. We saw limited evidence of the learning from incidents being routinely shared with staff and some staff were unable to tell us what happened after they had reported incidents. Records showed that GPs investigated incidents they were alerted to and recorded their investigation outcomes. Whilst in most cases the associated learning and recommended actions were clear, there were no systems in place to ensure that this had been shared with all relevant staff to minimise the risk of similar events occurring in the future.

Safeguarding

The practice had arrangements in place to effectively identify and report any potential or actual abuse of patients, both adults and children. One GP was the designated lead for safeguarding and attended specialist training and meetings. They also provided safeguarding information to all new staff on an individual basis. Staff we spoke with demonstrated that they knew how to raise any safeguarding concerns they may have with their line manager, in accordance with the practice's policy.

Staff had access to up to date reference material about safeguarding, including the contact details for local safeguarding teams. The practice required all new staff to complete online safeguarding training at a level appropriate to their role. Training records showed that most staff had received this training at the time of our inspection. However, periodic update training was not provided.

Patients who were considered to be vulnerable were identified on the patient records system so that staff were aware of those with particular needs. Records showed that such patients were discussed at practice meetings and concerns had been responded to appropriately. For example, children who repeatedly failed to attend for their immunisations were followed up by a GP. The GPs contacted local safeguarding nurses for specialist advice about any safeguarding concerns they had about patients.

Patients' personal information was protected by staff. A privacy policy set out the procedures for inputting and managing information on the patient records system consistently. This system was securely protected to prevent unauthorised access. We observed staff being careful not to disclose patient identifiable information in public areas. The GPs recorded prescribing information on the patient records system. A prescription clerk supported this process and managed repeat prescriptions. When a new patient registered at the practice their medical records were summarised by a dedicated member of staff to ensure correct information was available to clinicians. A protocol dictated the training required to undertake this role. This was provided internally by a GP. However, we noted that conversations within consulting rooms could be overheard by anyone standing in the corridor. This posed a risk to patients' confidentiality if staff raised their voices in order to be understood.

Monitoring safety and responding to risk

The practice had several systems and processes in place to promote patient safety within the practice environment and was planning to move to more suitable premises. Records showed that some environmental risks were effectively managed to protect staff and patients. For example, the water supply was tested six-monthly, as confirmed by certification. A security policy was in place, as were a burglar and panic alarms to protect the personal safety of staff and patients. The practice had an up to date fire risk assessment and records showed that routine checks were completed to ensure that fire risk was minimised. Staff understood their responsibilities in relation to fire safety and relevant guidance was displayed in most rooms. However, fire training was not provided for staff, with the exception of two who were designated fire marshals. The majority of staff worked part-time hours and therefore there was a risk that an appropriately trained fire marshal would not be on duty in the event of a fire.

There were no environmental risk assessments in place, or routine checks made on the building. We observed parts of the building were in a poor state of repair and hazards had not been identified. For example flooring in the waiting room was uneven and presented a trip hazard. Staff did not receive any training in health and safety. They told us that they routinely reported environmental hazards but these were not recorded. We found that the practice took action to address some environmental risks reactively and therefore not all risks to staff and patients were effectively managed.

Staff demonstrated that they understood their role and responsibilities in responding to medical emergencies, such as the circumstances in which they would summon a

Are services safe?

GP. A flow chart that directed them to respond to cardiac emergencies was displayed within the reception office. Nationally recognised emergency procedures were displayed in clinical areas. The practice required all staff to complete life support training annually and three staff were also trained as first aiders. However, at the time of our inspection six staff had not completed the required life support training within the preceding year and this had not been arranged. The certification of two first aiders had also lapsed; however, their training had been booked to take place by July 2014.

Appropriate emergency equipment and medicines were in place, including oxygen and an automated external defibrillator (An electrical device that provides a shock to the heart in an emergency). Records showed that these equipment and medicines were checked regularly. They were stored centrally within the building and accessible to all staff. However, we found that the equipment was cumbersome and stored in several containers. This meant there was a risk that it would not be transported to any emergency promptly. In addition, the container of emergency medicines could not be secured and there was a risk that it would inadvertently open on route to an emergency. We brought this to the practice's attention and they agreed to review these arrangements.

Medicines management

A limited range of medicines was stored in the practice; predominantly emergency medicines, vaccines and patients' prescribed injections, awaiting administration. Records showed that medicine stocks were regularly checked and rotated to support their integrity and timely use. However, we found one wound care preparation stored beyond its expiry date of February 2014 and brought this to staff's attention. They agreed to dispose of the item. Staff told us that vaccines were checked weekly, but this was not recorded to provide assurance of their availability and suitability for use.

Where medicines were required to be kept refrigerated they were stored securely and their recommended storage temperature was effectively maintained. Medicine fridge temperatures were monitored electronically and recorded to protect the integrity of these medicines. Occasional checking with a hand held thermometer was also carried out to ensure the effectiveness of the electronic system.

Incidents involving medicines were recorded and investigated and we saw examples of the actions taken in response to these incidents. For example, the separate storage of similarly packaged vaccines had been introduced following an incident where an incorrect vaccine had been given to a patient.

Cleanliness and infection control

We received mixed views from the patients we spoke with about general cleanliness at the practice and poor standards of cleanliness had also been the subject of two separate complaints received by the practice and the Care Quality Commission. Most patients said that they thought the practice was clean. However, one commented that they thought the premises were shabby. We found the practice to be visibly clean, although some surfaces in non-clinical areas were worn and could not be cleaned effectively.

Staff members understood their individual role in reducing the risk of patients acquiring an infection when visiting the surgery. For example, they demonstrated that they understood the need to remain at home if they had any potentially infectious illnesses and described offering similar advice to patients. Posters were displayed reminding staff about the management of clinical waste, hand washing and protecting their own health. Records confirmed that all relevant staff were encouraged to be regularly screened for, and inoculated against, Hepatitis B as appropriate.

Up to date, pertinent infection prevention and control (IPC) policies were in place and we saw that they were complied with. For example, arrangements were in place for the provision of personal protective equipment for clinical staff, including disposable gloves and aprons. Records showed that medicine fridges were cleaned every three months. Appropriate hand washing facilities were in place in all clinical areas. Treatment rooms had hard flooring and disposable privacy curtains were used. There was a clear system to ensure these curtains were changed periodically. A contract was in place to record and remove clinical or hazardous waste on a regular basis in accordance with the practice's protocol. Bio hazard spill packs were available to use for safely disposing of bodily fluids.

An independent infection prevention and control audit had been completed in April 2013 and this had identified many recommended improvements. We found that with the exception of two, these improvements had been completed. However, we observed some lapses in good

practice. For example, the soap dispenser in one toilet was empty, so patients could not wash their hands properly. Therefore the risk of infection was not being adequately monitored.

The practice provided minor injury and minor surgery services. Protocols dictated that routine cleaning procedures were carried out before and after any minor surgery. However, these were not documented, so compliance with the protocol could not be monitored and assured.

The identified lead for infection prevention and control told us that their role was solely clinical. It was not clear who was responsible for infection control in non-clinical areas of the practice and this was not being effectively monitored. General cleaning was carried out according to agreed schedules by an external contractor, who also checked that the schedules had been followed. A spot check template was in place but this was not being used. The practice did not carry out their own checks on the cleanliness of the premises and we found many gaps in the records of the contractor's checks, including five gaps for the month of May 2014.

Staffing and recruitment

There was an appropriate number of skilled clinical and non-clinical staff employed to deliver the service. Staff confirmed that there were usually sufficient staff numbers throughout practice opening hours. All staff groups provided reciprocal cover for their colleagues and locum or agency staff were rarely used. This promoted continuity for patients and for staff to be familiar with the practice population.

We looked at the arrangements in place to respond to changes in demand for the service, such as extreme weather. Many staff lived within walking distance of the practice and on previous occasions had walked to the practice to ensure the continuity of the service. We saw that the appointments system was amended to reflect the availability of clinical staff and thus optimise access for patients. For example, appointments were not booked for patients requiring a routine diabetes check unless the relevant nurse was available.

Dealing with Emergencies

The practice had a plan in place to ensure business continuity in the event of a significant emergency, for example, power failure. The plan was stored on the electronic shared drive and was accessible to all staff. However, whilst the lead GP and the practice manager retained copies of the plan at their homes, there was no hard copy available to staff within the practice should they need one. This posed a risk that staff may not respond to emergencies affecting business continuity as intended by the practice.

Equipment

Records showed that there were effective arrangements in place to check, service and recalibrate all clinical equipment, supported by an up to date protocol. For example, wheelchairs, emergency and blood testing equipment were checked monthly. Medical screening equipment was recalibrated in accordance with manufacturers' instructions. Up to date contracts supported some of these arrangements, such as portable appliance testing. This provided assurance that equipment was fit for purpose.

Only single-use instruments were used for minor operative procedures and appropriate disposal arrangements were in place. Stocks of small clinical items were checked and rotated to ensure their availability and timely use. However, we found a box of disposable clinical equipment that had been retained beyond its expiry date, making the integrity of this equipment questionable. We brought this to staff's attention and they agreed to dispose of the item.

Are services effective?

(for example, treatment is effective)

Summary of findings

Improvements were required to ensure the service was effective.

Clinical practice, including consent and prescribing, was delivered in accordance with nationally recognised best practice in primary care. However, clinical effectiveness was not discussed or managed systematically at practice level. Clinical audit was not planned and prioritised and clinical practice was not proactively monitored.

Clinical staff were appropriately qualified and had some opportunities to develop their skills and knowledge. Internal clinical learning events had lapsed due to GP's capacity and clinical supervision of nurses was not in place.

The practice positively engaged and worked in partnership with a range of other services to meet the needs of patients in a coordinated and effective way.

Patients had access to a variety of health promotion information and services that promoted a healthy lifestyle. Their health needs were assessed promptly and routinely reviewed.

Our findings

Promoting best practice

We saw examples of clinical practice that corresponded with nationally recognised best practice in primary care. Registers of patients with common conditions were in place and patients received routine screening and monitoring in line with recommended guidance. The practice reported that a high percentage of their patients took up the opportunity offered to them for routine health screening. One patient described to us how they had been recalled for regular check-ups for diabetes at nurse-led clinics.

Data showed that GPs prescribed in accordance with a locally agreed formulary, which was under review at the time of our inspection. The practice relied on commissioners to monitor their prescribing practice. Staff told us that the practice prescribing lead had established a positive dialogue with a prescribing adviser who conducted audits to monitor best prescribing practice and provided up to date advice to ensure that patients received appropriate medicines.

National alerts relating to medicines were routinely cascaded to clinical staff and actions were taken to ensure recommended practice was followed. For example, in response to an alert about a medicine to reduce blood cholesterol, the practice had identified all relevant patients and adjusted the medicines prescribed at each patient's scheduled medicines review appointment.

Arrangements were in place to ensure that the care, treatment and support for people approaching the end of their lives were managed in accordance with the Gold Standards Framework (GSF). The GSF is a nationally recognised multi-agency approach to palliative care. The practice had a policy for end of life care and one GP was identified as the palliative care lead. Regular multi-agency meetings took place to promote consistent and effective joint clinical management of patients with palliative needs.

Clinical staff told us that they identified best practice individually and highlighted such issues to colleagues. Minutes of practice meetings showed that national clinical initiatives and guidance were discussed by GPs and the practice manager. The minutes of a nurses' meeting also identified best practice discussions, such as health screening and wound care. These discussions helped to

Are services effective?

(for example, treatment is effective)

support consistent implementation of clinical practice and promote positive health outcomes for patients. However, there was no evident whole practice approach to clinical effectiveness. Meetings to discuss the promotion of best practice with all staff, or all clinical staff were not held.

Management, monitoring and improving outcomes for people

Clinical audits were conducted by the GP partners and a visiting pharmacy adviser to monitor best practice and improve outcomes for patients. This included, for example, an annual audit of the clinical management of patients who were living with diabetes. We looked at the records of six clinical audits carried out during the year preceding our inspection. We found that they generally reflected the individual GP's areas of interest and they contained clear outcomes and recommendations. However, staff told us that audit findings were not routinely shared with the wider staff group. There was no overall practice plan for clinical audits to ensure that they were prioritised and systematically covered key patient outcomes.

Best practice was not always monitored effectively. Staff told us that written consent was obtained only for minor surgical procedures and that for everything else people gave their verbal consent. The practice's consent policy stated that an annual audit of consent practice would be completed. However, this had not been completed to ensure that patients' consent was obtained consistently in line with the policy.

We saw no evidence that peer review was conducted routinely. GPs told us that it was becoming more difficult for them to accommodate audit and educational events within their working hours. These omissions limited the opportunities for GPs' clinical practice to be scrutinised by, or discussed between, colleagues.

Staffing

Records showed that a structured induction programme was in place that ensured that new staff became familiar with the service and were competent to undertake their role. The programme included one to one time with senior staff and close supervision until the staff member was deemed competent to work independently. Staff we spoke with confirmed that they had been effectively supported during their induction period so that they were confident and competent in their work.

The practice provided medical student placements every quarter and GPs completed continuing professional development and appraisal. However, the arrangements to ensure that clinicians maintained their knowledge and competence were not robust. The monitoring of GP performance relied upon independent GP appraisal and revalidation. Practice meetings were attended weekly by the GP partners and occasionally by the lead practice nurse. Minutes showed that discussions covered a mixture of clinical and operational matters. All GPs had attended external education events, such as one relating to the management of diabetes. However, internal clinical learning events to promote best practice had not been facilitated for some time. We were told that these had lapsed due to workload pressures. Nurses had the opportunity to attend clinical training according to their area of interest and they completed an annual appraisal. We found that the lead nurse had not completed a recent appraisal, although they had a development plan in place. No arrangements were in place for regular clinical supervision of the nursing team.

The performance of non-clinical staff was managed through annual appraisal. These staff completed training limited to safeguarding and managing medical emergencies. Other training to support the safe running of the practice, such as fire, and health and safety was not provided. However there was an expectation that all staff had a responsibility for the safety of the service. We found that disciplinary procedures had been carried out effectively and proportionately in accordance with the practice's policy. Most non-clinical staff, with the exception of the practice manager, received an appraisal, although not all staff produced a development plan as a result of their appraisal.

Working with other services

We saw examples of joint working with a number of external agencies to provide effective care and treatment to patients. We spoke with staff from local services that had regular contact with the practice. This included three support services for people with a learning disability and a pharmacy. All of these staff told us that the practice worked very positively with them to meet the needs of patients. Examples included the joint development of healthy lifestyle plans, prompt referrals to specialist health services and providing a timely response to any queries about prescriptions.

Are services effective?

(for example, treatment is effective)

A multi-agency palliative care meeting was held every two months. This was attended by practice staff and their external partners, including clinical specialists and the local hospices. This provided an opportunity to review all patients with cancer and other life limiting illnesses, identified as having palliative care needs, including those who had recently died. This joint working supported a consistent approach to palliative care that was focussed on patients' individual needs.

The practice engaged with community health and social care services, such as community matrons and district nurses, to support patients who were housebound, or whose needs were complex. For example, patients with leg ulcers were treated in the practice for six weeks before being referred on to community services, in line with local protocols. The practice had participated in a hospital admission avoidance pilot during which they identified patients at risk of recurrent admission. In conjunction with community services they had successfully provided enhanced support to these individuals at home.

We noted that clinicians experienced significant difficulties in working proactively with some community health services, which adversely impacted on the timeliness of patients receiving care and treatment. Staff told us that current referral arrangements prevented informal contact with community clinicians, such as psychiatric nurses, physiotherapists and district nurses. Whilst community midwives visited the practice twice a week to see patients, the practice had no contact with health visitors. We were told that it was difficult to facilitate timely access to a local memory clinic for patients who may have been developing dementia. Staff told us that these difficulties had occurred due reconfiguration of community services, which outside the practice's control.

Patients who required psychological support were promptly referred to specialist services. Counselling services were offered in-house and patients could refer themselves to this service. Psychological therapy programmes were accessible and included group and individual sessions.

A GP care adviser visited the practice twice a week to engage with patients about their social, housing or benefit needs. Staff referred patients directly to this adviser, who had access to the patient records system to retrieve referrals promptly. The adviser also provided occupational therapy assessments for people who required aids and adaptations to support their independence.

The practice corresponded effectively with hospital and GP out of hours services electronically and this promoted a timely exchange of patient information, including specialist referrals, discharge letters and out of hours interventions. Any paper correspondence from hospitals was date stamped and scanned onto the record system to provide full information to support clinical decision making.

Health, promotion and prevention

The practice had identified patients who had particular health needs through new patient checks and routine screening. Patient registers had been developed for most patient groups, including those requiring support and treatment in relation to long term medical conditions, or towards the end of their lives. All staff had access to these registers to ensure that appointments and screening were facilitated appropriately.

The practice was working to identify patients who may have been acting as informal carers for other patients, although no register of carers was in place at the time of our inspection. Carers were invited to identify themselves and this was recorded on their own record and that of the person they cared for. A designated carers' lead contacted potential carers and provided a pack of information that signposted them to other support.

Patients had access to a range of information to support them with achieving and maintaining healthy lifestyles. Written information was available in the practice about common medical conditions, support agencies, immunisations and other health promotion issues. Posters directed patients to select the appropriate health or social care service for their current needs. Further health promotion information was included in the practice leaflet and on the practice's website.

Screening and vaccination programmes were delivered in line with national guidance. Other nurse-led health promotion appointments were offered to patients, such as for smoking cessation. These were accommodated within general clinics.

Are services caring?

Summary of findings

The service was caring.

Patients and carers described the service positively. Most told us that they were involved in decisions about their care and treatment and that they were treated with dignity and respect by all staff.

Patients' diverse needs were considered and action was taken to meet them.

Patients' confidentiality was effectively protected by staff.

Arrangements were in place to make chaperones available when required. However it was unclear whether chaperones were being used in line with the practice's policy.

A patient survey undertaken in 2013 showed that people felt the doctors and nurses at the practice treated them with care and respect.

Patients were routinely asked for their consent to care and treatment. We saw that where patients did not have the capacity to consent, clinicians acted in accordance with recommended best practice.

Our findings

Respect, dignity, compassion and empathy

Most of the feedback we received from patients about the practice was complimentary about practice staff, saying that they were polite and caring. They said that they were happy with the services they received and would recommend the practice. One parent described to us how effectively a GP had built a rapport with their child during a consultation.

Most respondents to a 2013 national patient survey made positive comments in relation to the helpfulness of staff. Staff from local services supporting patients with a learning disability described the practice staff as very helpful and accommodating. They said that when they requested information about a patient's care or treatment, they always spoke with an appropriate person who knew the patient. During our inspection we observed how staff interacted with patients and their representatives. We saw that they were courteous and empathic in their approach.

The practice population was not diverse and patients could request to be seen by a clinician of their preferred gender. The main significant minority patient group were a group of adults and young people who had learning disabilities and were supported locally. We were told that families of overseas university students occasionally registered with the practice. Communication had not proved problematic as some family members spoke English. A telephone translation service was available to staff but most staff had never had the need to use it. Patient letters had also been professionally translated on occasions.

Staff demonstrated that they understood the importance of protecting patients' confidentiality. Checking patients' identity by using their dates of birth rather than their name was seen to be common practice. Staff told us that if a patient wanted to discuss something potentially sensitive with them, they would direct them to a private room. All of the patients we spoke with told us that they did not have any concerns about the confidentiality of their information. One patient told us that they used to be asked about the reason they were requesting an appointment, but this practice had ceased.

Patients' privacy and dignity was respected by staff. We saw that consultation and treatment room doors were labelled as such and kept closed during appointments and that

staff knocked before entering. A nurse advised that they could lock the treatment room door whilst carrying out intimate procedures. Curtains were in use around examination couches to further protect people's privacy and dignity.

We were told that chaperones were offered to people, particularly during intimate examinations or procedures. The practice had a chaperone policy and posters were displayed, informing people that chaperones were available. The use of chaperones was recorded in patient records. The practice's policy stated that staff should only act as a chaperone if they had been trained to do so. At the time of our inspection only two staff had completed this training. However, clinicians gave us differing accounts of who and how they used staff as chaperones and one staff member told us that they had acted as a chaperone with no training. It was unclear whether staff were working in line with the practice's policy.

Involvement in decisions and consent

The practice's consent policy reflected best practice and emphasised ensuring that patients understood the care and treatment they were consenting to, before providing their consent. The policy also highlighted the need to involve a relative or advocate in the consent process for people whose understanding may be limited. Staff described how they obtained consent and this reflected the practice's policy. Signed consent forms for clinical procedures were scanned onto the patient records system. Verbal consent was recorded on the patient record by the clinician who obtained it, supported by system prompts. We were told that patients' verbal consent was also routinely sought for medical students attending consultations or procedures.

Clinical staff demonstrated their awareness of the need to assess a patient's capacity to give informed consent and gave examples of what action they would take where a patient's capacity was impaired or in doubt. For example, requiring a parent's input when a young person did not understand the purpose of an immunisation. Staff supporting patients who had learning disabilities in the community described how clinicians acted in individual patients' best interests and considered their views. For example, one person was offered health screening in relation to medicines they were prescribed. The GP had understood that the required screening test would be distressing for the patient, had assessed the associated risk and decided not to undertake the procedure.

We received a mixed response from patients about their experience of being involved in decisions about their care. Two patients told us that they did not feel they had adequate time with, or explanation from, the clinician who had seen them. They said that appointments were sometimes rushed. The remaining patients told us that doctors and nurses gave full and adequate explanations and allowed them time to ask questions about their care and treatment. For example, one person described how the GP reviewed their prescribed medicines at every consultation to ensure they were taking them correctly.

Patients who were approaching the end of their lives (and their families) were supported to understand and make decisions about their prognosis, palliative care and treatment. Written information was available to these patients that covered practical issues, such as contact details of the professionals involved in their care. Decisions about whether or not a patient wished to be resuscitated in an emergency were reached with input from the patient and their representatives as appropriate. These decisions were recorded on the electronic record system and on a form that was given to the patient to keep at home, so that any visiting clinicians were aware of the individual's wishes. Bereaved patients could be referred to the local hospice service for specialist counselling and support.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs.

We found that the practice understood the individual needs of patients and made reasonable adjustments accordingly.

Staff made effective use of electronic systems to communicate with their patients.

The practice had arrangements in place to ensure that it could meet patient needs with minimal delay. Arrangements for appointments were regularly reviewed to ensure that patients could access the services they required in line with best practice.

The practice's arrangements ensured that patients' complaints were dealt with promptly and effectively. However, the provider's policy did not reflect best practice guidance and the learning from complaints was not systematically shared to drive improvement.

Our findings

Responding to and meeting people's needs

Patients we spoke with told us that they felt staff were responsive to their needs. One person said that if any problems were identified with their health, clinicians responded promptly.

Staff supporting patients with a learning disability in the community told us that they had developed good working relationships with the practice. They said that clinical and administrative staff understood their clients' needs and responded well to requests for a clinician's input, or telephone advice. They commented that the practice always returned their calls promptly and that practice staff understood that patients with autism needed to access services in a different way. For example, although fully mobile, some patients required a home visit from the GP.

Older people were supported by the practice in line with national guidance. Patients over 75 years had been allocated a 'usual' GP. In some cases this had been followed up by telephone contact between patients and their designated GPs. 'Senior' health checks were offered to older patients as part of a local hospital admission avoidance initiative. This sometimes led to the development of individual care packages for patients.

Patients were required to request repeat prescriptions in person, or in writing to reduce the risk of errors being made. However, the practice had agreed with a small number of patients, considered to be housebound, that they could make telephone requests for repeat prescriptions. A list of these patients was available to staff to ensure that requests were responded to correctly, and as agreed with the patient.

We saw evidence that healthcare assistants had developed clinical competencies to meet the diverse needs of the practice's patients. For example, they had achieved skills in a number of clinical procedures, such as spirometry (a test that can help diagnose and monitor various lung conditions) and ear syringing. These staff also assisted clinicians in providing minor surgery and smoking cessation services.

The practice had made reasonable adjustments to support patients with a disability to use the service. The building was on one level and accessible to patients who may have been physically impaired. Wheelchairs were available for

Are services responsive to people's needs?

(for example, to feedback?)

use on the premises. A hearing loop was available for those whose hearing was impaired and a toilet had been adapted for use by those with a physical disability. Equipment was accessible. The height of one examination couch could be adjusted and there were some adjustable chairs in the waiting room.

Access to the service

People knew how to access the service and could choose how to do so. New patients received an information pack that told them what to expect from the practice and this information was published on the practice's website. The appointments system was well advertised and people could choose to make appointments in person, online or by telephone. We saw that telephone calls were answered promptly. Most patients told us that they could usually obtain an appointment to see a doctor or nurse of their choice when they required one. One parent told us that they had good access to appointments for their children, although fitting them in around school hours could sometimes be challenging.

Some aspects of the management of appointments were under review by the practice. The availability of appointments for blood sample taking had recently been increased the in response to changes in local hospital services. This was being reviewed to ensure that the number of appointments and availability of home visits for blood taking met the needs of the practice population. A GP was undertaking an audit of the use of urgent appointments to determine the local need and the best way this could be managed. An evidence-based triage model had been proposed that included the duty GP speaking to patients who had asked to be seen 'urgently' to ensure they were allocated an appropriate and timely appointment.

It was unclear whether other access arrangements were based on patient needs. Saturday morning clinics and early morning appointments aimed to meet the needs of patients who were in full time work had recently been withdrawn by the practice. Staff told us that patients had not been informed or consulted about these changes in service and the need for such a service had not been properly assessed. However, we did not see any complaints relating to this and no patients we spoke with offered criticism about these changes. A GP told us that following a retrospective analysis of the use of these appointments they had concluded that these sessions were not required.

The practice made effective use of electronic systems to communicate with their patients. Examples included text message reminders for appointments, online appointment booking, prescription requests and a voluntary questionnaire. Patients arriving for an appointment checked in independently, using an electronic arrivals board. This reduced congestion at the reception desk and provided patients with information about the current waiting time. Consideration was being given to providing patients with their test and screening results by email and the risk associated with this was being assessed at the time of our inspection.

Concerns and complaints

Patients were offered information about how they could raise any concerns they may have about the service they received. The provider's complaints procedure was referred to in the practice leaflet and a complaints leaflet was available on the provider's website and in the waiting room. However, not all of the patients we spoke with could tell us how to make a complaint.

The practice's complaints policy identified appropriate lead staff and set out how complaints should be managed. However, this did not fully reflect Department of Health best practice guidance about complaints management. The practice's policy stated that patients who complained by letter should receive an acknowledgement within two working days and we could see that this always happened. However, these acknowledgement letters did not tell the complainant when they could expect to receive a full response from the provider as recommended nationally. This left complainants with no real idea of how quickly they could expect a final response to their letter.

We looked at a summary of five complaints and in detail at the correspondence relating to two complaints. We found that most complaints were concluded promptly and satisfactorily and that complainants were routinely offered the opportunity to discuss their complaint further with an appropriate member of practice staff. The quality and content of the responses that the provider had sent to the two complainants were courteous, informative and addressed the issues they had raised was adequate and included advice about how the complainant could escalate their complaint to external agencies should they wish to. Legal advice was sought by the practice for more complex complaints, although this sometimes delayed the response to the complainant.

Are services responsive to people's needs?

(for example, to feedback?)

Minutes showed that complaints were sometimes discussed between the practice manager and GP partners. However, we were unable to find any evidence of how learning from complaints was shared (as appropriate) with the wider staff group. This was a lost opportunity to drive service improvement and reduce the risk of recurrent complaints.

Are services well-led?

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

Summary of findings

Improvements were required to ensure the practice was well-led.

There was a well-defined leadership and management structure, and areas of responsibility for each GP partner were clear. However, development of the practice was not informed by individual, team or organisational objectives, or an overall plan

Some of the practice's policies and procedures were not implemented fully or consistently. This had a negative impact on the training and appraisal of staff and the use of audit and regular safety checks.

The practice did not demonstrate that they understood the need to systematically consider patients' experiences.

Some routine checks to monitor the safety of the service were not being either completed or recorded effectively

We saw some positive outcomes from clinical audit; however audits were not prioritised or coordinated effectively.

Some staff did not feel well supported and valued. They told us they were not consulted about the running of the practice and did not feel able to influence improvement.

The practice level arrangements to ensure continuous quality improvement were unclear. The practice did not ensure that staff learned from quality indicators, including patient feedback, audit, complaints and incidents.

Our findings

Leadership and culture

There were clear lead roles agreed within the practice, including those for operational and clinical leadership. For example GP leads had been identified for the management of safeguarding, staffing issues and the quality of care. GPs told us that they felt well supported by their partners. GP partners and senior staff described the practice as democratic and caring. However, this did not concur with the views expressed by some staff.

The practice mission statement was explicit, focussing on health promotion, equity of access and quality of care. However, this had not been reviewed for many years and had not been routinely highlighted to new staff.

Development of the practice was not informed by individual, team or organisational objectives, or an overall plan. Recent improvements had been mainly made reactively, such as the requirement for an audio typist to support timely management of correspondence about patients. The practice's focus at the time of our inspection was on the planned move to new premises in 2016. It was unclear how quality improvement was driven or prioritised in the interim.

The arrangements for engaging with all staff were inconsistent. Records showed that some staff meetings were held, including weekly practice meetings between GP partners and the practice manager. These included discussions about the quality and safety of the service, such as recruitment, incidents and audits. However, other staff and individual teams rarely met and no full staff meetings or training events had been held during the preceding year. Senior staff attributed this omission to the challenges associated with the high proportion of part-time staff employed.

Governance arrangements

Whilst the practice had some systems in place to ensure the quality and safety of the service, the governance framework was incomplete and not fully proactive. For example, there were no effective arrangements to support routine and regular audit and no annual reviews of incidents or complaints had been completed.

A range of policies and procedures were in place that had been reviewed in a timely way. Some were detailed and provided staff with information to manage risks associated

Are services well-led?

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

with their work. For example, the data entry management protocol set out how patient records should be managed to ensure completeness and consistency. Staff had access to these documents on an electronic shared drive. However, we found instances where policy and practice did not match. For example, staff's description of the use of chaperones was not consistent with the practice's policy. Some policy-driven audits had not been completed.

Staff management processes were clear and we saw evidence of effective disciplinary procedures and staff contracts. However, some staff files were incomplete and the documents they contained did not reflect the practice's policy. This had not been identified by the practice. The performance of staff was managed through annual appraisal and disciplinary procedures. Most staff received an appraisal, supported by an annual plan, although not all staff produced a development plan as a result of their appraisal. Two senior members of staff with responsibility for appraising other staff had not had an appraisal within the preceding year. One of them told us that they had not completed an appraisal within the previous five years.

Staff received a limited structured training programme that was recorded and monitored. However, we identified staff that had not undertaken the training required by the practice. The practice manager was aware of these shortfalls but they were not being addressed at the time of our inspection.

Systems to monitor and improve quality and improvement

The practice consistently attained good scores in relation to national primary medical service targets. There had been no recent scrutiny by any external body to assess outcomes for patients. However, a practice forum meeting, involving six local GP practices took place every two months and was attended by senior staff from the practice. Minutes showed that service quality and safety were discussed and the meeting provided an opportunity for sharing ideas about the implementation of national initiatives to optimise health outcomes.

There was no overall plan to ensure that clinical or other audits were prioritised, or carried out in a systematic or cyclical manner. Whilst we saw evidence of some audit activity, it was unclear how the outcome of most of these was used to improve the quality of the service. Exceptions were prescribing audits conducted by commissioners and appointments audits in progress, intended to inform the effective management of appointments.

Some audits had not been repeated in a timely manner to ensure that required improvements had been achieved, or maintained. A sample of five clinical audits included one undertaken in March 2013 that required a re-audit within six months. This had not been carried out. No recent audit of equipment had been completed, despite a previous audit identifying significant shortfalls. A wide range of improvements made in response to a 2013 infection prevention and control (IPC) audit had not been independently reviewed to ensure that all identified risks had been addressed. A further IPC audit was not expected to take place until 2015.

Some routine audits required by the practice's policies had not been completed. For example, A protocol for the summarisation of patient records stated that each GP would carry out monthly audits of two patients' records. We found that this had not been happening, so the content and quality of patient records could not be assured. However, we saw evidence that some improvements had been made to summarised information to enhance clarity and consistency. Similarly, a required annual consent audit had not been conducted.

Some routine checks to monitor the safety of the service were not being either completed or recorded effectively. This meant that the practice was not monitoring consistently, for example, the integrity of stock. Cleaning routines in relation to minor injury procedures and checks made on vaccines were not recorded, so compliance with the associated protocols was not being monitored. The risks associated with infection prevention were not being effectively monitored. Routine checks on general cleanliness and provision of hand washing facilities were not effective in ensuring that the practice's policies were followed.

Patient experience and involvement

There were no formal arrangements to seek, record or consider patients' views. Staff told us that patients provided informal feedback in person, or by email and that their comments were largely positive. The practice had conducted surveys of their patients in 2012 and 2013, which focussed mainly on access to appointments and customer care. These surveys had been triggered by

Are services well-led?

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

commissioners, rather than initiated by the practice and respondents represented less than 1% of the patient population. In preparation for their annual appraisal in early 2014, a GP had surveyed 38 patients, less that 0.5% of the practice population. An electronic survey was available on the practice's website; however completion by patients was voluntary.

We saw limited evidence of changes made in response to patient feedback. Responses to surveys had been analysed. However, areas for improvement had not been identified and the outcome of the surveys had not been shared with patients or staff. Service issues other than access and staff attitude had not been explored and there was no plan in place to conduct further surveys.

There was no effective Patient Participation Group (PPG) in place. The practice had however, established a 'virtual' PPG with over 80 people registering their interest. However, when consulted, the practice had received a very poor response from the PPG. The practice did not believe a PPG to be essential, but was considering how best to engage with patients about their experiences of the service. Staff told us that they also received patient feedback (and communicated information) through a local electronic forum ('blog') but it was not clear how this feedback had been used to inform how the service was run.

Staff engagement and involvement

It was not clear how effectively the practice was engaging with staff at all levels and we found that the evidence for this was conflicting. During our visit we spoke with 11 of the 15 staff on duty and received mixed views about their involvement and engagement with the practice. Senior staff expressed the view that all staff were informed and consulted about operational issues and that they were offered information about adverse events and complaints. Conversely, some of the more junior staff we spoke with said that they did not feel informed.

We found that very few meetings were held that involved the more junior staff. No team building or group training events had been facilitated. Minutes of one receptionists' meeting showed that this had been arranged in response to staff discontent about staffing and communication from senior staff. The tone of these minutes was largely instructive. However, minutes of another staff meeting included a record of planned operational improvements that had been agreed with staff. For example, stock management and practice performance targets.

Some administrative staff told us that they felt their views were not valued or acted upon. For example, administrative staff reported that suggestions they had made not to offer late afternoon appointments to older people in the winter (for safety reasons) had not been acted upon. Several staff expressed that they did not feel involved in policy or decision making and that they were not invited to comment or contribute. They told us that they received communication from the practice about service changes, or new guidance by email.

A whistleblowing policy was in place that advised staff about raising concerns with their line manager in the first instance. Staff told us that they felt able to do this and that they could raise any suggestions or concerns, but this rarely resulted in any feedback to them.

The nursing service was overseen by a lead GP and the lead nurse managed the small team of nurses and healthcare assistants. There were no formal arrangements in place for the nursing team to undertake clinical supervision and nurses' meetings happened only very occasionally. However, the team was mutually supportive on an informal basis and told us that they received timely clinical support and advice from GPs.

Learning and improvement

We saw limited evidence of how the impact and outcome of audit, complaints and incidents led to improvements, or how learning was shared with staff. The recommendations from untoward events were not routinely reviewed to ensure that required improvements were fully implemented. Whilst this sometimes happened, there was no system in place to ensure it occurred consistently.

Internal learning events had not happened for over a year and were not given high priority by the practice. Other forums, such as practice meetings for senior staff were used to discuss learning from adverse events, but this was not shared systematically to ensure staff awareness. This omission limited the practice's ability to promote service improvement and reduce the risk of recurrent complaints and incidents.

Identification and management of risk

Risks were not systematically identified and managed, although some risk areas, such as medicines management were being effectively controlled. The practice took action to address some environmental risks reactively and there were no arrangements in place for regular and on-going

Are services well-led?

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

assessment of environmental risk. Whilst the practice considered that all staff had a responsibility for fire and health and safety this was not explicit and no relevant training had been provided for staff. Conversely there was a contingency plan in place for emergencies affecting the service.

Personal risks to staff had been considered and adequate security arrangements were in place. Staff were aware of the risks of lone working and a maternity risk assessment had been completed for one staff member.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice had considered the safety of their older patients and made reasonable adjustments to support those patients with limited mobility to access the practice. Effective arrangements were in place to protect older people from abuse.

Older patients (and their families) were supported to understand and make decisions about their health, care and treatment, including at the end of their lives. Carers were identified and offered support.

Older patients were supported by the practice to ensure that the care and treatment they received was in line with national guidance.

The arrangements for access to the practice ensured that the individual needs of older patients, including those who were housebound or bereaved, were met.

Our findings

The practice's systems effectively identified and reported any potential or actual abuse of older patients. Those considered to be vulnerable were identified on the patient records system and such patients were discussed at practice meetings.

The practice had made reasonable adjustments to support patients with limited mobility to use the service. The building was accessible to older patients who may have been physically impaired. Equipment such as wheelchairs and a hearing loop was available and a toilet had been adapted for use by patients with a physical disability. Accessible furniture was provided. The height of one examination couch could be adjusted and there were adjustable chairs in the waiting room.

Older patients (and their families) were supported to understand and make decisions about their health, care and treatment. Staff ensured that older patients understood the care and treatment they were consenting to, before providing their consent. They also involved a patient's relative or advocate in the consent process if the patient's ability to understand was limited.

Decisions about whether or not a patient wished to be resuscitated in an emergency were reached with input from the patient and their representatives as appropriate. These decisions were recorded on a form that was given to the patient to keep at home, so that any visiting clinicians were aware of the individual's wishes.

The practice was working to identify patients who may have been acting as informal carers for older people. Carers were invited to identify themselves and this was recorded on their own record and that of the person they cared for. A designated carers' lead contacted potential carers and provided a pack of information that signposted them to other support.

Older patients were supported by the practice in line with national guidance. Patients over 75 years had been allocated a 'usual' GP. In some cases this had been

Older people

followed up by telephone contact between patients and their designated GPs. The practice's healthcare assistants had developed clinical competencies to meet the needs of older patients promptly. For example, had achieved skills in spirometry (a test that can help diagnose and monitor various lung conditions) and ear syringing.

'Senior' health checks were offered to older patients and the practice had identified older patients at risk of recurrent hospital admission. They had successfully provided enhanced support to these individuals at home in conjunction with other community health and social care services.

Patients were required to request repeat prescriptions in person, or in writing to reduce the risk of errors being made. However, the practice had agreed with a small number of older people who were housebound, that they could make telephone requests for repeat prescriptions. Staff were able to easily identify these patients to ensure that their requests were responded to appropriately.

The practice worked with community health services, to support older patients. For example, patients with leg ulcers were treated in line with local joint protocols.

Arrangements were in place to ensure that the care, treatment and support for older people approaching the end of their lives were managed in conjunction with other agencies. A practice palliative care lead had been identified and regular meetings took place attended by practice staff, clinical specialists and the local hospices. This provided an opportunity to review all patients with life limiting illnesses, identified as having palliative care needs and those who had recently died. This joint approach supported a consistent approach to palliative care that was focussed on patients' individual needs. Bereaved patients could be referred to the local hospice service for specialist counselling and support.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Patients who had common long-term medical conditions received care and treatment from the practice according to national guidelines.

There was no overall plan for audit to ensure that the management of all long term conditions was reviewed.

Staff, including those visiting the practice, had the appropriate skills to meet their needs.

Carers of patients who had long term conditions were being identified by the practice and provided with appropriate support.

The practice worked effectively with community health and social care services, such as community matrons, to support patients whose needs were complex.

The arrangements for access to the service ensured that the individual needs of patients with long term conditions, including those who were housebound, were met.

Our findings

Patients who had common long-term medical conditions received care and treatment from the practice according to national guidelines. This included prescribing for their needs and the effective management of repeat prescriptions. The practice had identified patients who had particular health needs through new patient checks and routine screening. Registers of patients with common conditions were in place and patients consistently received routine screening and monitoring.

Patients who were acting as informal carers for patients with long term debilitating conditions were being identified, although no register of carers was in place at the time of our inspection. Carer status was recorded on their own record and that of the patient they cared for. A designated carers' lead provided each identified carer with a pack of information that signposted them to other support.

The practice worked effectively with community health and social care services, such as community matrons, to support patients whose needs were complex. The practice had participated in a hospital admission avoidance initiative during which they identified patients at higher risk of being hospitalised due to their long-term conditions. In conjunction with community services they had successfully provided enhanced support to these individuals at home.

We saw that healthcare assistants had been developed to meet the diverse needs of patients with long-term conditions in a timely way. For example, they had achieved skills in a number of clinical procedures, such as spirometry (a test that can help diagnose and monitor various lung conditions) and delivering smoking cessation services.

People with long term conditions

The appointments system was managed proactively to reflect the availability of clinical staff and thus optimise access for patients. One patient described to us how they had been recalled for regular check-ups for diabetes at nurse-led clinics.

Patients were required to request repeat prescriptions in person, or in writing to reduce the risk of errors being made. However, the practice had agreed with a small number of patients, considered to be housebound due to their long-term conditions, that they could make telephone requests for repeat prescriptions.

Staff referred patients directly to the GP care adviser, who visited the practice twice a week to support and advise patients with complex needs about their social, housing or benefit needs. The adviser also provided timely occupational therapy assessments for people who required aids and adaptations to optimise their independence.

Clinical audits were conducted by the GP partners and a visiting pharmacy adviser to monitor and improve outcomes for patients. For example, an annual audit of patients who were living with diabetes. However, there was no overall plan for audit to ensure that the management of all long term conditions was reviewed.

All GPs had attended external education events to support up to date best practice. For example, one relating to the management of diabetes.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Patients aged up to 19 years made up 15.5% of the practice population.

Mothers, babies, children and young people were protected from abuse because the practice had effective arrangements in place that reflected best practice.

Although some risks were well managed, the practice did not always identify and address risks associated with the delivery of the service.

Patients and carers described the service positively and told us that they had good access to appointments.

Screening and vaccination programmes were delivered in line with national guidance. However, the checks on stocks of vaccines were not recorded to provide assurance of their availability and suitability for use.

Our findings

The practice had arrangements in place to effectively identify and report any potential or actual abuse of patients, both adults and children. Mothers, babies, children and young people who were considered to be vulnerable were recorded on the patient records system so that they could be easily identified. Records showed that such patients were discussed at practice meetings and that concerns had been responded to appropriately. For example, children who repeatedly failed to attend for their immunisations were followed up by a GP.

The practice did not always identify and address risks associated with the delivery of the service. A patient we spoke with told us that the waiting area was too small for children to play safely while waiting for their appointment.

Patients and carers described the service positively. A parent described to us how effectively a GP had built a rapport with their child during a consultation.

Screening and vaccination programmes were delivered in line with national guidance. Other nurse-led health promotion appointments were offered to patients, such as support for smoking cessation delivered by healthcare assistants.

Vaccines were stored securely and in a way that minimised the risks of errors occurring when vaccines were given. However, staff told us that vaccine stocks were checked weekly, but this was not recorded to provide assurance of their availability and suitability for use.

Clinical staff were aware of the need to assess a patient's capacity to give informed consent. They demonstrated that they understood best practice guidance in relation to consent and gave examples of what action they would take where a patient's capacity was impaired or in doubt. For example, a nurse had requested a parent's presence when a young person did not understand the purpose of an immunisation they were due to receive.

Mothers, babies, children and young people

Most patients told us that they could usually obtain an appointment to see a doctor or nurse of their choice when they required one. One parent said that they had reasonable access to appointments for their children, although fitting them in around school hours could sometimes be challenging.

A GP care adviser was available to speak to parents about their social, housing or benefit needs. Staff referred patients directly to the adviser who visited twice weekly.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Patients of working age had access to screening programmes in line with national guidance.

It was not clear whether appointment times were sufficiently flexible to accommodate patients who were in full-time employment. However, we did not see any complaints relating to availability of appointments and no patients we spoke with offered criticism about recent service changes.

Our findings

Screening and vaccination programmes were delivered in line with national guidance. Other nurse-led health promotion appointments were offered to patients, such as for smoking cessation. These were accommodated within general clinics and were therefore available at any time that clinics were in progress.

Most patients told us that they could usually obtain an appointment to see a doctor or nurse of their choice when they required one. Arrangements for appointments were regularly reviewed to ensure that patients could access the services they required in line with best practice. Saturday morning clinics and early morning ('extended hours') appointments aimed to meet the needs of patients who were in full time work had recently been withdrawn by the practice. A GP told us that following a retrospective analysis of the use of 'extended hours' appointments they had concluded that these sessions were not required. Staff told us that patients had not been informed or consulted about these changes in service and the need for such a service had not been properly assessed. However, we did not see any complaints relating to availability of appointments and no patients we spoke with offered criticism about these changes.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice population was not diverse and patients were able to request to be seen by a clinician of their preferred gender.

Vulnerable patients were protected from abuse because the practice had effective arrangements in place that reflected best practice.

Staff from three support services for people with a learning disability told us that they had developed good working relationships with the practice. They described the service they received and the practice staff positively, emphasising the practice's responsiveness to their clients' needs.

Care and treatment was provided in line with nationally recognised clinical guidelines, particularly in relation to end of life care.

Our findings

The practice's arrangements to identify and report any potential or actual abuse of vulnerable patients were effective and reflected best practice. Patients, who were considered to be vulnerable for whatever reason, were identified on the patient records system so that staff were aware of those with particular needs. Records showed that such patients were discussed at practice meetings and that concerns had been responded to appropriately.

The practice population was not diverse and patients could request to be seen by a clinician of their preferred gender. We were told that families of overseas university students occasionally registered with the practice. Staff said that communication had not proved problematic as some family members spoke English. A telephone translation service was available to staff but most staff had never had the need to use it. Patient letters had also been professionally translated on occasions.

During our inspection we spoke with staff from local services that had regular contact with the practice. This included three community support services for people with a learning disability whose staff told us that they had developed good working relationships with the practice. They said that clinical and administrative staff understood their clients' needs and responded well to requests for a clinician's input, or telephone advice. Examples of positive outcomes for patients included the joint development of healthy lifestyle plans, prompt referrals to specialist health services and providing a timely response to any queries about prescriptions. They told us that they received a prompt response to urgent requests for care and treatment, such as when a patient contracted an infection.

People in vulnerable circumstances who may have poor access to primary care

One commented that practice staff understood that patients with autism needed to access services in a different way. For example, although fully mobile, some patients required a home visit from the GP.

The practice was working to identify patients who were acting as informal carers for other patients, although no register of carers was in place at the time of our inspection. Carer status was recorded on their own record and that of the person they cared for. A designated carers' lead provided potential carers with a pack of information that signposted them to other support.

Arrangements were in place to ensure that the care, treatment and support for people approaching the end of their lives were managed in accordance with nationally recognised guidance about palliative care. Regular multi-agency meetings took place to promote consistent and effective joint clinical management of patients with palliative needs. These were attended by practice staff and their external partners, including clinical specialists and the local hospices. They provided an opportunity to review all patients with cancer and other life limiting illnesses, identified as having palliative care needs. This joint working supported a consistent approach that was focussed on patients' individual needs.

The practice's consent policy highlighted the need to involve a relative or advocate in the consent process for people whose understanding was limited. Staff described how they obtained consent and this reflected the practice's policy. Staff supporting patients who had learning disabilities in the community described how clinicians acted in individual patients' best interests and considered their views. For example, one patient was offered health screening in relation to medicines they were prescribed. The GP had understood that the required screening test would be distressing for the patient, had assessed the associated risk and decided not to undertake the procedure.

Patients were required to request repeat prescriptions in person, or in writing to reduce the risk of errors being made. However, the practice had agreed with a small number of patients, considered to be housebound, that they could make telephone requests for repeat prescriptions. A list of these patients was available to staff to ensure that requests were responded to correctly, and as agreed with the patient.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Patients experiencing poor mental health were protected from abuse because the practice had effective arrangements in place that reflected best practice.

Effective and timely referrals were made for patients who required specialist psychological counselling and treatment, or support and advice.

Staff obtained consent from patients in line with national guidance. They were aware of the need to assess a patient's mental capacity to give informed consent, particularly in relation to mental health.

Our findings

The practice had effective arrangements to identify and report any potential or actual abuse of patients. Those who were considered to be vulnerable because of their mental health were identified on the patient records system. This information was also shared with the GP out of hours service when a patient's mental health was significantly deteriorating, or they were in crisis. Records showed that such patients were discussed at practice meetings and that concerns had been responded to appropriately.

Patients who required psychological support were promptly referred to specialist services. Counselling services were offered in-house to which patients could refer themselves. Psychological therapy programmes were accessible and included group and individual sessions.

Clinical staff were aware of the need to assess a patient's capacity to give informed consent and gave examples of what action they would take where a patient's capacity was impaired or in doubt. The practice's consent policy emphasised ensuring that patients understood the care and treatment they were consenting to, before providing their consent. It also highlighted the need to involve a relative or advocate in the consent process for people whose understanding may be limited. Staff described how they obtained consent and this reflected the practice's policy.

A GP care adviser met with patients to discuss their social, housing or benefit needs. Staff referred patients directly to the adviser, who had access to the patient records system to retrieve referrals and provide timely advice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010, Assessing and monitoring the quality of service provision. People who used services and others were not protected against the risks of inappropriate care and treatment because the practice did not have an effective system to regularly assess and monitor the safety and quality of service. Regulation 10 (1);(2)(b)(i) (c)(i) (e)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010, Supporting workers. People who used services were not assured that practice staff were supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1)(a)