Firsway Health Centre

Quality Report

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Date of inspection visit: 16 January 2015
Date of publication: 19/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Firsway Health Centre on 16 January 2015. Overall the practice is rated as requires improvement.

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

- Information from safety alerts and significant events were discussed at clinical meetings. However, some staff were not aware of the reporting procedure and identified learning needs were not always actioned.
- Data showed patient outcomes were in line with the clinical commissioning group (CCG) average.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments.
- The practice had a number of policies and procedures to govern activity, but some were outdated and some did not contain enough information to guide staff.
- The practice had a set of values and a strategy in place for improvements. Due to circumstances beyond their control they had been unable to implement the strategy.

The areas where the provider must make improvements are:

- The provider must ensure there are processes in place to seek the views of patients to enable an informed view in relation to the standard of care provided. Where it has been identified that improvements to the service are required, for example additional training needs to be arranged following a significant event, these should be monitored and put in place in a timely manner.

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- The provider must ensure they take reasonable steps to identify the possibility of abuse and prevent it before it occurs.
- The provider must ensure systems are in place to assess the risk of and prevent, detect and control the spread of health care associated infections.
- The provider must ensure people are protected against the risks associated with the unsafe use and management of medicines by having arrangements in place for the safekeeping of medicines at the correct temperature.
- The provider must ensure they operate an effective recruitment system by obtaining the information required under Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 and ensuring staff are of good character.
- The provider must ensure staff are appropriately supported in relation to their responsibilities by providing appropriate training, professional development, supervision and appraisal. Healthcare professionals must be enabled to provide evidence to their relevant professional body that they continue to meet the professional standards required as a condition of their registration.

In addition the provider should:

- The provider should take action to ensure the working hours of all staff reflect the needs of patients.
- The provider should ensure there are procedures in place for dealing with emergencies which are reasonably expected to arise from time to time.
- The provider should improve the ways patients can communicate with the practice. For example, patients found it very difficult to get through to the practice on the telephone and it was not possible to book appointments on-line.
- The provider should ensure all staff knew the procedure to follow if a patient made a complaint.
- The provider should ensure a protocol is in place regarding what action to take if patients do not attend an appointment for a health check or review.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Basic life support training had been carried out for staff in December 2013 but staff told us they could not remember being trained in cardio-pulmonary resuscitation (CPR). Oxygen and an automatic external defibrillator (AED) were usually kept at the practice. The AED had been sent for repairs, and we saw no evidence of checks being carried out to ensure the AED or oxygen were available and ready for use.

Not all staff, including clinical staff who had worked at the practice for several years, had received safeguarding training. Safeguarding policies did not contain clear guidance. Staff had not been trained in their responsibilities while acting as a chaperone and some told us they did not witness the patients' examinations taking place. The practice had made a decision not to ask for references for new staff and instead assess their suitability after they had started work. Their employment history and reason they left past employment was not checked. Evidence of identity was not always confirmed. Disclosure and Barring Service (DBS) checks had not been carried out for relevant staff including four of the five nurses, the healthcare assistants, the phlebotomist and reception staff who carried out chaperone duties.

An audit in May 2014 had identified that the temperature of fridges used to store vaccines were not recorded and monitored. Although the governance and performance manager had supplied nurses with books to record the fridge temperatures this was not being done on a daily basis and the practice had not identified this. Practice nurses had been provided with temperature record books but these were not completed daily meaning the temperature of medicines was not monitored. Some staff, including a practice nurse and the phlebotomist who had both worked at the practice for several years had never been given training in the prevention and control of infection. The phlebotomist had never been given formal training in taking bloods and did not wear gloves while carrying out the procedure.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, and there are areas where improvements must be made. Although a training plan was in place for 2015 training for staff had not been a priority. Training was not up to date in several areas. The continuing professional development (CPD) of nurses was not

Summary of findings

monitored and not all nurses attended their required training updates. Until April 2014 appraisals for nurses and non-clinical staff had not been carried out for several years. The executive director who started work in April had appraised approximately 55 to 60% of staff at the time of our inspection. There had been no management of staff with poor performance. The hours staff, in particular nursing staff, worked had not been reviewed for several years, with the practice allowing staff to work the hours they wished and not the hours that met the needs of patients.

Are services caring?

Good

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

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services, and there are areas where improvements should be made. Feedback from patients and evidence seen during the inspection reported that although emergency appointments could usually be made routine appointment were more difficult to access. Patients also reported that it was very difficult to get through to the practice by telephone. The practice confirmed this was an on-going issue they were trying to resolve. Although patients were invited for appointments to manage their long term conditions or for routine health checks such as cervical smears, there was no protocol to follow if they failed to attend their appointment. The hours some staff worked did not meet the needs of the patients. The practice had a complaints policy. Although they recorded and investigated complaints they did not follow their policy in that verbal complaints were not always recorded. Staff were unsure about the procedure to follow when a patient complained.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led, and there are areas where improvements must be made. The executive director had put a vision and strategy in place from April 2014. However, due to circumstances outside the control of the practice, it had not been implemented. The GPs worked well as a team but other staff, including the nurses and reception staff, did not

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have the same focus. Regular meetings took place for GPs and managers, but not for other staff. Some of the policies in place were out of date and others did not contain the guidance required to direct staff in some aspects of their work.

The practice had a virtual PPG with 55 members. The practice told us most of these had never been active. A patient satisfaction survey was carried out in 2014 and this was the only communication the PPG had during the year. Nine patients responded. This means the survey was issued to 0.3% of patients and 0.05% of patients responded. The results could not reflect the views on the whole practice.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. Patients with a higher risk of an unplanned hospital admission had a care plan in place. However, due to a change in the practice computer systems the tools to update the care plans were not in place. Home visits were carried out for older people as required and the practice nurses also visited people to administer their flu vaccination. Health checks were not routinely carried out for patients aged 75 or over.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. Patients with a long term condition were invited to attend an appointment with a nurse. However, there was no protocol to follow if a patient did not attend the appointment.

The practice held a register of patients requiring palliative care. They held multi-disciplinary meetings to discuss the care of these patients and performed above the national average for managing these patients.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. Not all staff had received training in safeguarding children and the safeguarding policies did not provide clear guidance to staff. GP appointments were available outside school hours but there was not always a nurse on duty after 3.30pm. GPs had a good relationship with community nurses but practice nurses told us they never met with community nurses and usually worked alone.

The fridges used to store childhood immunisations did not have their temperature checked on a daily basis so the practice could not be sure they had been stored at the correct temperature.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). Although GP appointments were available for extended hours on two days a week the nurses did not work late. It was sometimes very difficult to get through to the practice by telephone and there was no facility to book appointments on-line.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. They had an above average performance for managing this register.

Some staff had not been trained in how to recognise abuse in vulnerable adults. The policies in place did not contain clear guidance. Appropriate staff had also not had a Disclosure and Barring Service (DBS) check carried out.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Patients could be referred to organisations for counselling and there was a counselling service on the premises.

It was difficult to get through to the practice on the telephone and this made making an appointment difficult. Routine appointments were usually only available several days in advance.

Summary of findings

What people who use the service say

On the day of our inspection we spoke with seven patients and reviewed 21 CQC comments cards that had been completed by patients.

Of the seven patients we spoke with three told us they had made their appointment that day and two the previous day. They told us they could usually access an emergency appointment if required although they often had to wait several days to access a routine appointment. They said it could be difficult to get through to the practice by telephone. Patients told us staff were caring and no areas of concern about the practice were highlighted.

Of the 21 CQC comments cards we reviewed nine mentioned difficulty getting through to the practice on the telephone. Patients commented they could be on the telephone for 20 to 30 minutes before it was answered. Some said that by the time they got through on the telephone the appointments for the day had been taken.

We reviewed 12 comments cards where patients spoke positively of the practice. They commented that staff were caring, respectful and courteous and said reception staff usually greeted them in a friendly manner. Patients commented they could usually get an appointment in an emergency but the waiting times when they had an appointment could be long, at times over an hour.

We reviewed the results of the most recent national GP patient survey. This reported that:

- 85% of respondents thought the GP was good at giving them enough time.
- 85% of respondents thought the GP was good at listening to them.
- 91% of respondents found the receptionists helpful.

These figures were similar to or above the clinical commissioning group (CCG) average.

The survey recorded that 72% of respondents found it easy to get through on the telephone. This was below the CCG average of 81%.

Areas for improvement

Action the service MUST take to improve

- The provider must ensure there are processes in place to seek the views of patients to enable an informed view in relation to the standard of care provided. Where it has been identified that improvements to the service are required, for example additional training needs to be arranged following a significant event, these should be monitored and put in place in a timely manner.
- The provider must ensure they take reasonable steps to identify the possibility of abuse and prevent it before it occurs.
- The provider must ensure systems are in place to assess the risk of and prevent, detect and control the spread of health care associated infections.
- The provider must ensure people are protected against the risks associated with the unsafe use and management of medicines by having arrangements in place for the safekeeping of medicines at the correct temperature.
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Action the service SHOULD take to improve

- The provider should take action to ensure the working hours of all staff reflect the needs of patients.
- The provider should ensure there are procedures in place for dealing with emergencies which are reasonably expected to arise from time to time.
- The provider should improve the ways patients can communicate with the practice. For example, patients found it very difficult to get through to the practice on the telephone and it was not possible to book appointments on-line.
- The provider should ensure all staff know the procedure to follow if a patient makes a complaint.
- The provider should ensure a protocol is in place regarding that action to take if a patient does not attend an appointment for a health check or review.

Firsway Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience.

Background to Firsway Health Centre

Firsway Health Centre moved to its current purpose built premises in Sale in 2009. At this time three practices, who had previously shared a building, merged in to one.

There was a large staff team consisting of seven partners, two salaried GPs, five practice nurses, two healthcare assistants, a phlebotomist, and a management and administrative team.

The practice delivers commissioned services to approximately 16,200 patients under a General Medical Services contract. Information from Public Health England told us there was a higher percentage of patients in the 40 to 59 age range than the average in England. There were also more patients in paid work or full time education and less patients unemployed than the England average.

The executive director has been in post since April 2014. They have put a new strategy in place to make improvements to the practice but the management team has suffered several setbacks and due to circumstances beyond their control the implementation of the strategy has been delayed.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Firsway Health Centre had opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Detailed findings

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

The working-age population and those recently retired (including students)

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

People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 January 2015. We reviewed all areas that the practice operated, including the administrative areas. We received 21 completed patient comment cards and spoke with seven patients during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with GPs, a practice nurse, the phlebotomist, members of the management team and receptionists.

Inadequate

Are services safe?

Our findings

Safe track record

During our inspection GPs told us they checked for national patient safety alerts and made sure relevant staff were aware of the alerts. They did not formally record the alert. Some staff told us they were aware of how to report incidents; they would either be brought to the attention of a more senior staff member or recorded in the incident book. Other staff, including a practice nurse, told us they were unaware of how to report incidents as they had not received training. They told us this was due to them being unavailable on the days when training had been provided and alternative dates not being suggested by the practice

We saw evidence that safety records and incidents had been discussed at practice meetings. We saw that meetings had been held more regularly since April 2014 and the minutes kept had improved since then.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw that five significant events had been recorded during the 12 months prior to our inspection. The records described the events and the actions taken, and any implemented learning was also recorded. However, there was no evidence of the learning being monitored or put in place. For example, following a significant event in October 2014 where a GP did not know how to use a piece of equipment in an emergency, refresher training was to be put in place. At the time of our inspection this had not been implemented.

We saw evidence that significant events were discussed at clinical meetings following them being recorded. When the appropriate action had been taken the governance and performance manager kept all the information.

The governance and performance manager told us that staff had been told how to report significant events but they preferred to tell a manager who would then follow the required procedure.

GPs told us they disseminated national patient safety alerts to appropriate staff but they did not keep a record of this. Not all the staff we spoke with were aware of any safety alerts at the practice.

Reliable safety systems and processes including safeguarding

We saw the child protection protocol, which was undated. This gave information about recognising child abuse and children in need, and said that all staff would receive child protection training at least once every two years and within six months of induction. The document did not give guidance on what procedure to follow to report suspected abuse and contact numbers of relevant safeguarding teams were not provided.

The practice had a short vulnerable adults document in place which was undated. This two page document described types of abuse and indications of abuse. There was no guidance about how to make a safeguarding referral or who to contact for advice. The governance and performance manager told us they did hold information about who to contact for advice but this was not kept with the policies.

We saw that all GPs had completed level two safeguarding training for adults and children, with the safeguarding lead having completed level three. The other GPs were attending a level three safeguarding course during the month of our inspection.

Most staff had received training in safeguarding vulnerable adults and children. However, some staff who had been at the practice over six months had received no training. The governance and performance manager told us this was because some staff did not work on the days training had been arranged. We spoke with the phlebotomist who told us they had never been given training in safeguarding adults or children and they had worked at the practice for eight years.

We saw that safeguarding had been discussed at a clinical meeting in November 2014, with the safeguarding lead issuing a reminder to GPs to complete the appropriate form if necessary and ensure the lead GP was kept informed.

We saw the chaperone policy that was dated 2012. The policy stated that where non-clinical staff acted as a chaperone they would have received training that included where they should stand and what to watch for. It also stated the chaperone should annotate the patient's records to record if there were any issues during the examination. Instructions about acting as a chaperone were recorded in the policy, and this included the need to stand inside the curtain and watch the procedure. We spoke with reception

staff who had acted as a chaperone for patients during intimate examinations. They told us they had not received any training and not been told where to stand. Some told us they stood outside the curtain and did not actually witness the procedure taking place.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Emergency medicines were stored in a trolley kept in the reception area on the ground floor. Staff told us that the tray containing emergency medicines was removed at the end of each day and locked away.

The medicines kept at the practice for use in an emergency were appropriate. We saw there was a stock list of all the emergency medicines kept, although this did not include the medicines that were kept in GPs' bags. All the medicines we checked were within their expiry dates. We saw no records of checks taking place to ensure the medicines were available and within their expiry dates. Medicines kept in the GPs bags were also appropriate and in date.

During an infection prevention and control inspection by the clinical commissioning group (CCG) in May 2014 it had been highlighted that the temperature of fridges that contained medicines, including vaccines, were not being checked. There were several of these fridges throughout the practice. The governance and performance manager told us they had purchased log books to record fridge temperatures immediately following the inspection and practice nurses had been given the responsibility of carrying out the checks on their own fridges. We saw that the temperature of fridges was not routinely checked on a daily basis. Nurses checked the temperature of their fridge only on the days they worked, with one fridge usually being checked only twice a week. There was no protocol in place to ensure other staff checked the temperature on other days. The action plan put in place following the inspection in May 2014 had highlighted the need for deputies to be nominated so fridges were checked daily. Also, only the actual temperature at the time of the check was recorded. The minimum and maximum temperature range should be recorded to ensure medicines are stored at the recommended temperatures. The practice had been unaware that the checks were not being completed.

We saw that prescriptions had been discussed during a practice meeting on 12 November 2014. It had been decided that to improve the system each GP would have two baskets for their prescriptions; one for urgent prescriptions and one for routine.

Cleanliness and infection control

During our inspection we found the practice to be visibly clean and uncluttered. Personal protective clothing was available throughout the practice and hand wash and paper towels were next to all hand wash basins. The practice used disposable privacy curtains. These had last been changed in January 2014. The advice from the National Patient Safety Agency (NPSA) is that disposable curtains should be changed every six months. It was recorded that showerheads were cleaned every three months and weekly flushing out of little used outlets took place weekly. We saw evidence that Legionella testing had been carried out by an external company in December 2014.

Systems were in place for ensuring the practice was regularly cleaned. There was a contract in place with a cleaning company who attended daily at the end of the surgery. We saw there was a cleaning schedule in place and cleaners recorded that they had carried out the required cleaning each time they attended. The governance and performance manager told us they informally monitored the standard of the cleaning and could contact the company if there were any issues, but standards were usually high. They told us that spillage kits were kept in the cleaners store and this was accessible by practice staff if they were required during the day.

We saw the infection prevention and control policy, recorded as being updated in 2012. The policy stated it should be reviewed annually by the infection prevention and control lead, who was the governance and performance manager. The policy gave brief guidance on how to carry out some procedures such as hand washing and obtaining specimens. It stated that all staff should be trained in infection control, and the Primary Care Trust (PCT) would carry out quarterly checks at the practice. The governance and performance manager told us that since April 2013, when PCTs were replaced by CCGs, the check was only being carried out once a year.

We saw the most recent infection prevention control audit that had been carried out by the CCG in May 2014. Several areas of concern had been highlighted and the governance

and performance manager told us this was due to the practice being unaware guidance had changed. They told us that some improvements had been made but they had not carried out all areas highlighted on their action plan. This included arranging training for staff.

We saw that most staff had received on-line infection control training. The action plan following the audit in May 2014 stated that face to face training would be carried out for all staff within six months. This had not been carried out or arranged. Some staff, including a practice nurse and the phlebotomist, told us the practice had never given them any training on infection prevention and control either face to face or on-line. They were unaware of there being a lead in infection control and unaware of the infection control policy. The phlebotomist told us they had not received any formal training on taking blood from patients but the healthcare assistant had told them what to do. They told us they did not wear gloves when taking bloods.

We saw the practice's infection control file. This contained out of date policies, for example, the needle stick and sharps policy was seven years old and pre-dated the merge to the current practice. Training information was included in the file and there was no record of the nurses or healthcare assistant receiving training. The practice told us that most information was now kept separately.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence that equipment was tested and maintained regularly. All portable electrical equipment was routinely tested each year. Calibration of relevant equipment had been carried out during 2014.

Staffing and recruitment

We saw the recruitment policy that was stated to have been reviewed in 2013. The policy did not contain information such as the requirement for the identity of staff to be checked or the need for some staff to have a Disclosure and Barring Service (DBS) check carried out. The policy stated that a start date for new staff was not agreed until satisfactory references had been received. We saw that a staff handbook was being finalised and this contained more in-depth information about recruitment checks that would be carried out.

We looked at the personnel files for six staff, including staff who had recently started work. Proof of identification was held for two of these staff members. No references were held. The governance and performance manager told us they used to ask for references but decided to stop as they found all references had been positive. They had made a decision that the ability of staff to carry out their duties would be assessed during the three month probationary period. No checks had been carried out to confirm where staff had worked previously and why they had left previous jobs.

The governance and performance manager told us they did not carry out a DBS check for all staff but did for clinical staff and staff who performed chaperone duties. We looked at the DBS checks that had been completed. No DBS check had been carried out for four of the practice nurses, two healthcare assistants or the phlebotomist. Checks had not been carried out for reception staff who acted as chaperones.

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

We saw that locum GPs were used when required. The practice used a locum agency who supplied evidence that the required employment checks of the locum GPs had been carried out. They told us they tried to use regular locum GPs to provide continuity. The GPs were flexible and we saw there were enough GPs to cover the surgeries in place. The practice was also in the process of recruiting additional GPs. We also saw a staffing plan for administrative staff. The working hours of staff did not always reflect the needs of the practice. We heard this was due to historical contracts that were in place. New staff were being recruited and they would be contracted to work the hours the practice required, for example covering extended hours. We saw the plan indicated that by the end of March 2015 all the new staff would be in place. There was no flexibility regarding working hours built into the contract of nursing staff. The management team acknowledged their working hours did not meet the needs of the patients and plans were in place to address this.

Inadequate

Are services safe?

The practice was in the process of recruiting new salaried GPs for the practice. Interviews had been arranged. A nurse practitioner who had worked at the practice had recently left, and the practice were having difficulty recruiting new nursing staff.

Monitoring safety and responding to risk

The practice had a health and safety file and a risk assessment file in place.

The health and safety file did not contain up to date information or guidance. For example, data sheets relating to the safety of cleaning substances was dated 2002, the infection control policy was from 2004 and the risk assessment policy was from 2009.

The risk assessment file also contained some out of date information with several risk assessments being dated 2009. However, this file also contained relevant information. This included a fire security check that had been carried out in July 2014. Records were kept of regular checks being carried out for the means of escape from a fire, emergency lights tests, and fire extinguisher checks. These were up to date with checks being carried out during the week prior to our inspection.

We saw that regular checks of the environment were carried out informally and changes were made where required, although these checks were not formalised.

Arrangements to deal with emergencies and major incidents

We saw the business continuity plan, which was undated. This contained information about the loss of the computer or telephone system, but not the loss of any other services. The plan did not contain sufficient information to guide staff in an emergency. It stated that the plan would be put in place when instructed to do so by the CCG.

We saw that oxygen was available on the ground floor and first floor. This was ready for use but we saw no evidence of checks being carried out to ensure this. Staff told us there was usually an external automatic defibrillator (AED), but this had been sent away for repair. We saw no evidence of checks being carried out to ensure the defibrillator was ready for use. Medicines for use in an emergency were available and these were within their expiry date. All computers had a panic button on them to alert other staff in an emergency.

We saw that a fire risk assessment had been carried out and regular checks on fire safety equipment and escape routes also occurred. Not all staff, including staff who had worked at the practice for several years, had received fire training. We saw the training plan for 2015 and fire safety was included for March 2015.

Cardio-pulmonary resuscitation (CPR) training had last been carried out for staff in December 2013. Guidance from the Resuscitation Council (UK) states that CPR training should be updated for clinical staff every year and it is best practice for non-clinical staff to have annual updates. We spoke to one staff member who told us they had been trained in how to use the AED but could not remember having CPR training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The updates were received via the practice's computer system. We saw that regular clinical meetings had taken place from April 2014 and the minutes provided evidence that new guidelines were discussed. Care and treatment for individual patients, for example patients requiring palliative care, was also discussed by the clinical team during these meetings. These confirmed that each patient received support to achieve the best health outcome for them.

The GPs told us they took the lead in specialist clinical areas such as diabetes and orthopaedics. We saw that peer reviews were carried out for individual GPs as part of a clinical commissioning group (CCG) initiative. GPs told us they planned to start internal peer review so individual outcomes were discussed within the practice. GPs also told us they worked well as a team and provided support and advice to colleagues.

All patients over the age of 75 had a named GP. Although in the past over 75 health checks had been carried out there had not been the capacity within the nursing team to carry these out recently.

A practice nurse or healthcare assistant carried out health checks for new patients. The nurse told us they carried out routine checks such as blood pressure and weight, and discussed lifestyle choices, but they did not usually take bloods from patients. Patients requiring a blood test were referred to the phlebotomist. The practice nurse told us there was no protocol to follow if a patient did not attend for a check.

The executive partner showed us data from the CCG of the practice's performance. This showed that they were mainly performing in line with national expectations. We saw that following a visit by the CCG in October 2014 some recommendations were made. The practice was working to put in place an action plan to be submitted to the CCG in February 2015.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. There were quality improvement processes in place to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with the CCG. We saw evidence of the clinical audits cycles that had been carried out. These included the audits on sore throats, rheumatology and prescribing. Audit cycles also showed there had been a positive outcome for patients. We saw evidence that clinical audits were discussed during meetings held between GPs so they were all aware of the results and improvements that could be made.

Meeting minutes provided us with evidence that where necessary patients were discussed in detail. We saw that patients were treated holistically with their individual circumstances being taken into account. Examples included patients with dementia who may have difficulty attending appointments for other conditions.

A register was held for patients with learning disabilities or those who required palliative care. The practice was performing better than the national average for the management of their learning disabilities and palliative care registers. We saw evidence that multi-disciplinary team meetings were held every three months as a minimum for patients on the palliative care register. The practice was also performing better than the national average for the percentage of patients over the age of 65 who had received a flu vaccination.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. The GPs regularly attended meetings with other GPs in the CCG area. The practice nurse we spoke with told us they did not attend meetings, did not have links with community nurses and they mostly worked alone.

There was a protocol for repeat prescribing which was in line with national guidance. One of the GPs was the

Requires improvement

Are services effective?

(for example, treatment is effective)

practice prescribing lead. There was also a prescribing manager within the practice. The prescribing manager told us the system for managing repeat prescriptions was having difficulties due to a change in the practice's computer system during December 2014. GPs authorised repeat medicines to be prescribed to patients. When a repeat prescription was requested by a patient and a GP had authorised this, reception staff could deal with the request. They approached the prescribing manager if they had any queries. The prescribing manager told us they could ask a GP for advice if required. GPs told us audits had not been carried out to evaluate the success of the prescribing system.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The governance and performance manager told us that not all training was up to date, but there was a plan in place to achieve training goals during 2015. We saw the plan that stated mandatory training, including safeguarding and fire safety training, had been planned for between January and October 2015. We were told that previously there had not been an emphasis on training staff. However there had been a recent recruitment drive for administrative staff and it was expected that a full team would be in place by March 2015. The governance and performance manager told us that staff who had worked at the practice for several years did not engage with training and this had not previously been dealt with. Training was starting again from January 2015 to ensure new staff were appropriately trained and it was envisaged that all staff would be part of a new training programme.

The staff training records we reviewed showed that most staff had received some mandatory training. However some staff who had worked at the practice for several years had not received training such as for safeguarding. We were told this was due to staff not working on the days training had been arranged for. In addition, although records showed some staff had received training such as for cardio-pulmonary resuscitation (CPR), staff members could not remember having this training. The training plan we saw stated that additional training, such as learning disability awareness and customer service training was planned. The phlebotomist told us they had never had any formal training on how to take blood samples; the healthcare assistant had showed her what to do. We saw no evidence that competency had been assessed. In addition we saw no evidence of the training the healthcare assistant had received.

We saw that following an incident in October 2014 it had been highlighted that not all GPs were able to use some equipment that could be required in an emergency. Refresher training was to be arranged for the GPs but this had not been carried out at the time of our inspection.

The GPs monitored their continuing professional development (CPD) and where required had been revalidated. Their appraisals were up to date. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council (GMC).

The executive director and GP who took the lead in nursing told us that CPD of nurses was not monitored. Appraisals had historically not been carried out for nurses although plans were in place to introduce appraisals for all staff within the practice. The nurse we spoke with confirmed this. They told us they had not had an appraisal for over five years and they said they were not up to date with some of their training, for example cytology training. There had been no nurse lead at the practice so a GP had recently taken on the responsibility of leading the practice nurse team. We spoke with this GP who was unaware that revalidation for nurses was being brought in from December 2015. As part of revalidation nurses would have to declare they had met certain standards, including meeting the requirements for CPD.

There was little interaction between the GPs and the practice nurses and it was unclear what the nurses' responsibilities were. Under a previous management structure the practice nurses had been able to decide their own working hours and this was causing problems as the working hours did not fit in with the needs of the patients. We saw that the work carried out by the executive director had highlighted this and plans had been made to make improvements. Due to circumstances outside the control of the practice these plans had not yet been put in place.

Since being appointed in April 2014 the executive director had started to have appraisal meetings with staff. These had been difficult because staff had not previously had

Requires improvement

Are services effective?

(for example, treatment is effective)

appraisals, but approximately 55-60% of staff had had an appraisal meeting at the time of our inspection. The executive director told us that objectives had not been set as part of these appraisals; they were being used as a baseline and as a way for the management team to find out exactly what each staff member did. From 2009, when the practices merged to become Firsway Health Centre, until April 2014, this had been unclear. As staff performance had not been monitored areas of poor performance had not been formally recognised and no steps had been taken to manage any issues.

The practice was a training practice. Medical students from the University of Manchester and doctors who were qualified and were undertaking GP training regularly attended the practice for training. Positive feedback from the university and the Deanery had been received by the practice. External speakers attended clinical meetings as part of the training of the students and doctors.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services electronically. The GPs saw these documents and results and took the action required.

Practice meeting minutes provided evidence that district nurses attended the meetings at intervals. They attended on 22 October 2014. The district nurses told GPs they would try to be available at 12.30pm each day to take telephone calls if required or speak to GPs in person. There was a district nurse based in the building. However, the practice nurses told us they had little contact with district nurses and they usually worked alone. They said they were unsure of other service available in the building and concentrated on their own role.

The GPs told us of a new scheme supported by the CCG. Community nurses would carry out visits to residential and nursing homes as part of a team to evaluate care for frail and elderly patients.

We saw several other services were provided in the practice's premises. These included an atrial fibrillation clinic, urology clinic, a mental health team and a carers' service.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

Managers meetings were held once a week, and a manager told us meetings for administrative staff were held approximately once a quarter. The GPs explained that the meetings had only recently become formalised. The most recent meeting minutes we reviewed showed relevant details were being discussed and recorded for the managers meetings. The governance and performance manager told the administrative staff meetings had only recently been put in place and the minutes of the last one were not available.

The practice had a virtual patient participation group (PPG). Emails were sent to the group asking for their opinion on aspects of the practice. This was not an established group and the executive director had plans in place to help the group become more effective.

Consent to care and treatment

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

The clinical staff we spoke with explained when written consent was required and when verbal or implied consent was acceptable. We saw the forms used by the practice to record written consent.

The GPs and nurses we spoke with had an understanding of the Gillick competencies. These help clinicians to identify young people aged under 16 who have the legal capacity to consent to medical examination and treatment. Nurses told us they would see patients under the age of 16 but would discuss with them the reasons why they wished to attend alone.

The GPs and nurses were aware of the Mental Capacity Act 2005 and knew the procedure to follow if they thought a patient did not have the capacity to consent to care or treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The governance and performance manager told us new patient health checks had recently restarted. They had been suspended due to the capacity of the nurses. The practice nurse told us they took a medical history, discussed lifestyle choices and checked the patient's blood pressure and weight. They said they did not take bloods from patients and if this was required they would be referred to the phlebotomist. There was no protocol to follow if a patient missed an appointment.

Patients over the age of 75 had a named GP. Over 75s health checks were not being offered at the time of our inspection. The governance and performance manager told us this was due to the capacity of the nurses.

Minutes from the practice meeting on 22 October 2014 provided evidence that health promotion was discussed. They considered ways of improving the take-up rate for cervical smears. We also saw evidence that the practice carried out dementia screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance was on the whole in line with CCG expectations. The practice nurse told us nurses and the healthcare assistant carried out home visits to give the flu vaccination to housebound patients. They had also held two Saturday clinics for flu vaccinations. The nurse told us that if a patient did not attend a clinic no follow up action was taken.

We saw that the reception area contained information about clinics held at the practice, long term conditions and various health promotion leaflets. However, there were no health promotion notice boards and other notice boards were not well-organised.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent national GP patient survey and the 2014 satisfaction survey carried out by the practice. The national survey results showed 85% of respondents thought the GP was good at giving them enough time (clinical commissioning group (CCG) average 87%), with 88% of respondents saying the same of the practice nurse (CCG average 79%). We saw 85% of respondents thought the GP was good at listening to them (CCG average 89%) and 81% thought the GP was good at treating them with care and concern (CCG average 85%).These figures for the practice nurses were 88% (CCG average 77%) and 88% (CCG average 78%) respectively. We also saw that 91% of respondents found the receptionists helpful (CCG average 89%). The practice survey had not asked questions relating to respect or involvement.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards. The majority of cards spoke positively about being greeted by friendly staff. Patients said staff were polite and clinicians caring. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The patients we asked told us they did not have a problem with privacy at the reception desk. We saw that privacy could be an issue. However, the receptionists we spoke with told us they acknowledged this and would take patients to one side if they wished to have a private conversation with a patient. They told us there was not always a private room available.

Care planning and involvement in decisions about care and treatment

We looked at the most recent national GP patient survey results. We saw that 87% of respondents thought GPs were good at explaining tests and treatment (CCG average 84%) and 77% thought GPs were good at involving them in decisions about their care (CCG average 83%). The figures for the nurses were 85% (CCG average 75%) and 83% (CCG average 66%) respectively. Some patients we spoke with told us they were given options about their care and treatment.

We spoke with GPs and practice nurses and they had a good understanding of the Gillick competencies and when a young person was able to advocate for themselves. Young people under the age of 16 were, when appropriate, able to access appointments themselves without an adult being present. We saw that when appropriate consent was discussed with patients and forms were completed when necessary.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

We saw evidence that a counselling service was available to patients in the practice's premises. GPs referred patients for this. Other specific counselling was available, for example for patients who had suffered bereavement. GPs and nurses were able to identify the need for the service and would signpost patients to this. They were then required to self-refer.

Information was available in the waiting room to signpost patients to local support groups. Carers had been identified and were signposted to a local carers support group.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We saw that housebound patients were easily identifiable. Practice nurses and the healthcare assistant visited these patients at home to administer their flu vaccination if appropriate.

Information on the prevalence of disease was kept and this was appropriately reported to the clinical commissioning group (CCG) as part of their Quality and Outcomes Framework (QOF) submission.

The executive GP had a lead role in the CCG and was heavily involved in the commissioning of services. They therefore had regular engagement meetings with the CCG to discuss local needs and service improvements.

Nurses told us they managed chronic diseases and carried out the annual reviews for patients with long term conditions. They told us the health checks for patients over the age of 75 had been suspended due to a lack of capacity within the nursing team. All patients over the age of 75 had a named GP.

The practice told us they had care plans in place for patients with a higher risk of an unplanned hospital admission. However, they said that due to a change in their practice computer system during December 2014 they did not have the facility to update the care plans. At the time of our inspection this was being rectified.

The practice nurse told us that different staff were responsible for recalling patients for health reviews such as for long term conditions. They said that if the patient did not attend their appointment they sometimes received a telephone call or sometimes another letter. They tried to see them on an opportunistic basis if they attended the practice for another matter. They told us there was no system in place for recalling patients who failed to attend for a smear test, but patients were offered the procedure if they attended the practice at a future date for another matter.

We saw evidence in meeting minutes that patients who required palliative care were regularly discussed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The governance and performance manager told us they had access to a face to face interpreter service and did not use a telephone service. They said this was rarely used as they only had a very small percentage of patients who did not speak English as a first language, and they had one patient who required a sign language interpreter. The practice nurse told us they had a number to arrange telephone interpreters but had never needed to use it. Other staff we spoke with told us they knew interpreters were available and they informed the governance and performance manager if one was required.

Staff had not completed equality and diversity training but it was included in the training plan for 2015.

The premises were purpose built, had two storeys, and was designed to meet the needs of people with disabilities. There was level access to the entrance and the practice had electronic doors. The premises were spacious and had a passenger lift. All areas were accessible to patients using a wheelchair or pushing a pram. The waiting areas were spacious. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

GPs worked different hours with appointments available between 8.30am and 5.30pm Monday to Friday. Extended hours were also available between 6.30pm and 8.30pm on Mondays and Thursdays. The surgery hours of the different GPs were available on the practice website, but there was no information about the overall opening hours.

The executive partner and executive director told us that although there was some flexibility in the hours GPs worked, and they were able to have the extended hours surgeries, there was no flexibility within the nursing team. Due to an agreement during a previous management structure the nurses worked their chosen hours and these did not meet the needs of patients at the practice. For example, of the five nurses only one worked each Monday morning, Thursday afternoon and Friday afternoon. Their start and finish times were also limited which made it difficult for patients who worked to arrange an appointment. The executive director told us although this had previously not been managed they had identified this was an issue that needed action.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The patients we spoke with told us they were able to access an on the day GP appointment in an emergency. However, they told us routine appointments were difficult to arrange. On the day of our inspection we checked the availability of appointments at 10.45am. We saw there were three emergency appointments available for the same day, the first one being at 4.40pm. The next available routine appointment was in six working days. There was no monitoring of the appointment system to test its effectiveness.

We looked at the results of the most recent GP survey. In this 77% said they were happy with the opening hours. This was the same as the CCG average.

In most recent national GP patient survey 72% of respondents said it was easy to get through to the practice by telephone. The CCG average was 81%. The satisfaction had decreased since the previous survey. The executive partner explained that a new telephone system that had been purchased was not meeting their needs. Patients were regularly trying to get through to the practice for a long time. They were in negotiations with the telephone company about making improvements. The patients we spoke with told us the time they spent on the telephone was variable, from between one minute and six to seven minutes. Several patients commented on CQC comments cards that it was very difficult to get through to the practice on the telephone. One patient told us it took 20-30 minutes to get through.

Patients told us and patients who completed CQC comments cards stated that when they had an appointment it was not unusual to be kept waiting for a long time before being able to see their clinician.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The governance and performance manager was the lead for complaints with a GP overseeing the process. We saw the written complaints procedure for the practice. It was stated that the procedure would be made available to staff, but the staff we spoke with were unaware of it. Staff said they would approach a senior member of staff if a patient complained, but they did not know what to do if a patient made a verbal complaint. The procedure stated a written record would be made of verbal complaints. However, the governance and performance manager told us not all verbal complaints were recorded.

We saw a summary of the complaints received in the 12 months prior to our inspection. We saw that a record was kept of when complaints were received, brief details, what the solution was, the date it was resolved and any earning that had been implemented following the complaint.

There was information within the practice and on the website about how patients could make a complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

We saw that the practice had a statement of values. This had five points and stated staff would give their names and treat people with respect, they would treat people as individuals, they would give people information on their services, they would ask people's opinion through the patient participation group (PPG) and they would maintain systems and equipment to protect people's health.

We spoke with ten staff members. They did not all know about the values document but they described the way they worked and this related to the values of the practice. The executive director told us they held a meeting with staff when they started work at the practice in April 2014. This was for all staff and it was to give them an overview of how the practice would work and changes that were to be made. We spoke with a staff member who had worked at the practice for many years. They told us they had attended the meeting but they did not know what had been said at it.

We saw the strategy that had been put in place when the executive director started work in April 2014. They had a clear vision and GPs and managers were aware of this. Other staff within the practice were reluctant to change; their systems of working had been in place for many years. Although the strategy was in place implementation had been delayed. This was partly due to nurse recruitment difficulties and exceptional staff sickness, but also due to exceptional unforeseen circumstances that the practice had no control over. The executive GP told us further unforeseen difficulties could further delay the plan being implemented, but they were aware of their duty to make the necessary improvements to the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Several of these were very old, and we saw some documents dated 2009, when the practice moved to their current premises. Some of the staff we spoke with were unaware of policies being in place for aspects of their work.

The current leadership structure had been in place since April 2014, when the executive director started work at the practice. The management team told us that when the three practices merged in 2009 this was in name only, and the new practice did not work well together. The GPs had started to work more closely and have regular meetings but this had not occurred for nursing and administrative staff, and the issues had not been managed. When the executive director joined the practice in April 2014 they quickly put plans in place to make improvements to the practice. These were well set out and detailed. However, although changes were starting to be made the practice improvements had been delayed. There had been issues with staffing and there had been times of exceptional illness within the clinical team. Some of the delays had been due to exceptional circumstances beyond the control of the practice.

A meeting was held each week and these alternated between clinical and partner meetings. We saw the minutes for some recent meetings and they contained obvious mistakes relating to dates of occurrences. For example, the minutes of the meeting on 17 December 2014 gave information about what would happen during a future change to the practice's computer system on 9 December 2014. Managers meetings were held every week. The governance and performance manager told us the practice was not used to having governance meetings, but the executive director planned to start these as soon as possible. They told us meetings for receptionists and administrative staff had started to be held once a quarter. There were no minutes from these meetings available. One staff member told us one meeting had been held but they were unaware of others being arranged.

There was a CCG wide system of peer reviewing the work of GPs. The practice kept records of these but there was no evidence of learning from the results. The executive GP told us they were going to start a peer review system within the practice. We saw evidence that significant events were discussed at clinical meetings.

The governance and performance manager kept a file containing various risk assessments for the practice. This was not well organised and although some aspects of risk, such as fire safety and the storage of oxygen cylinders, were kept up to date others were not. Several risk assessments were dated 2009 with no evidence of them being revisited since then.

Leadership, openness and transparency

We saw that meetings for GPs and managers were held regularly. Meetings for other staff were said to be every quarter. One staff member told us they had attended one

Are services well-led?

Requires improvement

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

meeting but were unaware of another being arranged. Some reception staff told us they were unaware of any meetings being held for receptionists. We also spoke with a nurse who had worked at the practice for several years. They told us they never attended meetings as they were held on a day they didn't work. They said communications within the practice were poor. Another staff member told us they attended a meeting when the executive director started work in April 2014 but none had been held since. They said they relied on other staff to give them updates relating to the practice.

The executive director told us they had started to send all staff a 'team brief' email to give them updates about the practice. This was in response to staff telling them that communications were poor. They currently intended to send the emails every two months but hoped to have monthly updates in the future. A member of reception staff told us they received this email.

The executive director had started to review the roles of all staff, with the nursing team being prioritised. They told us the nursing team had old contracts from before the three practices merged. These had not been renewed in 2009 when the practice became one. Nursing staff worked the same hours and performed the same duties as before the merger and this had not been managed. The management team had realised they were not aware of exactly what each staff member did or was responsible for. Not all nurses performed all the duties of a practice nurse. The nurses had worked at their respective practices for many years and the practice was having difficulty recruiting a new nurse to join the team.

Seeking and acting on feedback from patients, public and staff

The practice had a virtual patient participation group (PPG), with 55 members. Members did not meet in person but were sent information by email and asked to comment on it. During 2014 the only communication with the PPG had been for the practice's patient survey. Nine members had replied so the practice survey results were based on nine responses from a practice population of approximately 16,200 patients.

The service manager for operations told us patients were asked if they wanted to join the PPG when they registered at the practice. They thought most did not realise what the PPG was and had not responded to any emails that had been sent to them. Staff at the practice were unsure of how the PPG worked. One staff member told us it was a virtual group but they did not know how patients joined and another told us the PPG had meetings but they did not know where or how often. The executive director was hoping to make the PPG a meaningful group that met to discuss improvements at the practice.

There was a comments box in the reception area. A manager told us they looked at comments periodically but these were not formally actioned. They were not recorded and there was no evidence of changes being made due to comments made by patients.

Staff, other than GPs and managers, told us that regular meetings did not take place. Appraisals had not taken place for staff for many years, although the executive director had started to arrange appraisal meetings for staff since April 2014. Some staff told us there was low morale amongst staff and communication within the practice was poor.

Management lead through learning and improvement

Practice nurses told us their continuing professional development (CPD) was not monitored. One told us they knew some of their on-going training, such as in cytology, needed to be updated. There had been no nurse lead and the practice had been unsuccessful when they tried to recruit one. A GP had been made the lead for the nurses. They told us they did not have any training information about the nurses and not all nurses attended study days. They said they did not know how the nurses met the registration requirements of the Nursing and Midwifery Council (NMC).

One of the GPs was an appraiser for the CCG. The GPs were up to date with their appraisals and had either been revalidated or knew their date for revalidation.

We saw that the executive director had identified that staff had not been appraised for several years. They had carried out appraisal meetings for 55-60% of staff since April 2014. They told us objectives had not been set during these meetings. They were a new concept to staff and they had been used as a way of finding out exactly what each staff member's duties were. Previously there was no robust information about this. The previous management team had not carried out appraisals for nurses and one nurse

Are services well-led?

Requires improvement

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

told us they had not had an appraisal for over five years. The executive director told us their aim was to have a nurse lead who would carry out nurses' appraisals and other managers would be involved in appraising their team.

The practice was a GP training practice and had regular medical students from the university as well as well as GP registrars (qualified doctors training to become a GP). We saw that the practice had received positive feedback from the university and the deanery regarding the quality of their training, and also positive feedback from students.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Effective procedures to identify the possibility of abuse and prevent it before it occurred were not in place.** **Regulation 11 (1) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were not protected against identifiable risks of acquiring a health care associated infection because effective systems to assess the risk of and prevent, detect and control the spread of health care associated infections were not in place.** **Regulation 12 (1) (2) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not protected against the unsafe use of medicines.** **Regulation 13**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	Effective recruitment procedures ensuring all required information about staff was held and staff were of good character were not in place. Regulation 21 (a) (i) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Workers were not supported by means of receiving appropriate training, supervision and appraisal. Healthcare professionals were not supported to provide evidence they continued to meet the professional standards required for their on-going registration with the professional body. Regulation 23 (1) (a) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision When risks were identified they were not monitored in a way that protected patients from the risk of unsafe care and treatment. The views of patients were not sought in a way which gave the provider an informed view of the standard of care and treatment they provided. Regulation 10 (1) (b) (2) (e)