

# Dr Om Sharma

## Quality Report

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

## Ratings

### Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We inspected this service on 10 October 2014 as part of our new comprehensive inspection programme. We had previously inspected this practice on 23 September 2013, 1 and 9 October 2013 and found that the practice did not meet required standards in safeguarding children and vulnerable adults; management of medicines; safety of equipment; requirements relating to workers; supporting workers and assessing and monitoring the quality of service provision. The practice sent us an action plan telling us what they would do to address these issues. We returned on 2 July 2014 and found they still did not meet required standards in management of medicines; safety of equipment; requirements relating to workers; supporting workers and assessing and monitoring the quality of service provision. We told the practice to take immediate action to address issues relating to workers and assessing and monitoring the quality of service provision. The practice sent us an action plan informing us how they would address the remaining issues. We

returned to the practice on 3 September 2014 and found that required standards had still not been met for requirements relating to workers and assessing and monitoring the quality of service provision.

At this inspection we found that adequate improvements had been made in safeguarding children and vulnerable adults; management of medicines; safety of equipment; requirements relating to workers and supporting workers.

There had been some improvement in assessing and monitoring the quality of the service provision. However, there were still concerns regarding the analysis of significant events, the lack of risk assessments to keep patients safe from the risk of harm and the failure to seek the views of patients. We met with stakeholders on 28 October 2014 to discuss our concerns and to identify ways to support the practice in the changes they need to make. We will continue to monitor the situation and will re-inspect the practice to ensure that the required improvements have been carried out.

The overall rating for this service is requires improvement. We found the practice to be good in the effective, caring and responsive domains but required

# Summary of findings

improvement in the safe and well led domains. We found the practice provided good care to people with long term conditions, families, children and young people and people in vulnerable circumstances. Improvements were required in the care of older people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients told us they were satisfied with the appointments system and said it met their needs.
- Patients were not kept safe because arrangements were not in place to investigate and learn from key safety risks. The practice did not have a system in place for monitoring significant events over time.
- Systems were not in place to keep patients safe from the risk and spread of infection because where infection control audits had identified problems, action plans had not been put in place to monitor and make the required improvements.
- Evidence we reviewed demonstrated that most patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Identify, assess and manage risks relating to the health, welfare and safety of patients and others who may be at risk within the practice. This must include risk assessments to manage the lack of access to emergency equipment during a medical emergency; the emergency management of patients during a GP home visit; Control of Substances Hazardous to Health (COSHH) and the prevention of the spread of infection in accordance with Regulation 10(1)(a) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

- Analyse significant events and incidents that resulted in and had the potential to result in harm to patients in accordance with Regulation 10(2)(c)(i) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.
- Regularly seek the views of patients and those acting on their behalf to enable the provider to come to an informed view in the relation of the standard of care and treatment provided to patients in accordance with Regulation 10 (2)(e) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.
- Second audit cycles are carried out to ensure that changes made to patients' care and treatment have made improvements to their health outcomes.

In addition the provider should ensure:

- Care plans are completed for patients where a need has been identified.
- Health promotion advice and complaints leaflets are made available for patients whose first language is not English.
- A system for recording the serial numbers of prescriptions pads is introduced to prevent access to medicines in the event of theft of the GPs' prescription pads used for home visits.
- An infection control lead responsible for infection control is identified and appropriate training given.
- Recruitment procedures include an explanation of gaps in employment history.
- Records are put in place to monitor that oxygen and airway management equipment are in date and fit for purpose.
- All staff receive training in the Mental Capacity Act 2005.
- A business plan is put in place identifying long term plans, vision and strategy to meet the needs of their practice population.

**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?

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, systems were not in place to address identified infection control issues and staff had not received the appropriate infection control training.

Requires improvement



### Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidelines were referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs have been identified and planned. The practice had identified appraisals and training plans for all staff. Multidisciplinary working was evidenced.

Good



### Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



### Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was

Good



# Summary of findings

well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

## Are services well-led?

The practice is rated as requires improvement for well-led. The practice had a short term vision and was in the process of developing a strategy to deliver it. A leadership structure was being developed and staff reported a clear awareness of who to go to for support. The practice had a number of policies and procedures to govern activity. Governance meetings were held regularly.

There had been some improvement in assessing and monitoring the quality of the service provision since our last inspection. However, there were still concerns regarding the analysis of significant events, the lack of risk assessments to keep patients safe from the risk of harm and the failure to seek the views of patients. We met with stakeholders on 28 October 2014 to discuss our concerns and to identify ways to support the practice in the changes they need to make. We will continue to monitor the situation and will re-inspect the practice to ensure that the required improvements have been carried out.

**Requires improvement**



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as requires improvement for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. When needed, longer appointments and home visits were available for older people. Care and treatment of older people did not always reflect current evidence-based practice. A list of older patients who required a care plan for the avoidance of unplanned hospital admissions had been generated but care plans were not in place on the day of our inspection. The leadership of the practice had started to engage with this patient group to look at further options to improve service delivery.

**Requires improvement**



### People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group who had a sudden deterioration in health. When needed longer appointments and home visits were available. All patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The nurse had also received training to reflect the needs of the high ethnic population. An example of this was training in reducing the risk of hypoglycaemia (low blood sugar) during Ramadan. A Ramadan Health Guide which had been translated into other languages was available to support the advice given by the nurse to non-English speaking patients.

**Good**



### Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, multi-disciplinary meetings were held between the practice and Health Visitors. Immunisation rates were relatively high for all standard childhood immunisations. Where immunisation rates fell below the national average, the practice demonstrated an awareness of the reasons for this and described what they were doing to address it. Patients told us and we saw evidence that children and young people were treated in an

**Good**



# Summary of findings

age appropriate way and recognised as individuals. Appointments were available after school hours. We were provided with good examples of joint working with midwives, health visitors and social care.

## **Working age people (including those recently retired and students)**

The practice is rated as requires improvement for working-age people (including those recently retired and students). The practice patient age profile was mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. The practice offered extended opening hours for appointments on Monday and online appointments with the practice nurse. However, patients were unable to book online appointments with the GP or request online repeat prescriptions. Health promotion advice was offered but limited accessible health promotion material was available in other languages to reflect the needs of the practice's large ethnic population.

**Requires improvement**



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those approaching the end of their life, asylum seekers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. Information inviting them to their health check and a health action plan were provided in an easy read format ensuring that the method of communicating with patients with learning disabilities was effective and met their needs. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and had systems in place to identify those patients who were most at risk. The practice had sign-posted vulnerable patients to various support groups and other organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

**Good**



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). The practice held a register that identified patients experiencing poor mental health or dementia. There was a system in

**Requires improvement**



## Summary of findings

place to alert staff of their needs. There was a system in place for people experiencing poor mental health to receive an annual physical and mental health check. Nationally reported data from the Quality and Outcomes Framework (QOF) demonstrated that the practice had met the national average in reviewing the care of people experiencing poor mental health and people with a diagnosis of dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including In-sight and talking therapies. Significant events were not always recorded when people who experienced poor mental health became violent at the practice. There was no evidence of learning when this occurred.



# Summary of findings

## What people who use the service say

Five of the six patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the eight patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were overwhelmingly positive. Patients told us the staff were always caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients we

spoke with on the day of our inspection told us they experienced problems getting through to the practice on the phone to make an appointment. Most patients however told us the appointment system was easy to use and met their needs. The results of the GP national survey supported these findings.

The results from the National Patient Survey showed that 86% of patients said that their overall experience of the practice was good and that 62% of patients would recommend the practice to someone new to the area.

## Areas for improvement

### Action the service **MUST** take to improve

The provider must identify, assess and manage risks relating to the health, welfare and safety of patients and others who may be at risk within the practice. This must include risk assessments to manage the lack of access to emergency equipment during a medical emergency; the emergency management of patients during a GP home visit; Control of Substances Hazardous to Health (COSHH) and the prevention of the spread of infection in accordance with Regulation 10(1)(b) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

The provider must analyse significant events and incidents that resulted in and had the potential to result in harm to patients in accordance with Regulation 10(2)(c)(i) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

The provider must regularly seek the views of patients and those acting on their behalf to enable the provider to come to an informed view in the relation of the standard of care and treatment provided to patients in accordance with Regulation 10(2)(e) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

Carry out a second audit cycle once a clinical audit has been carried out to ensure that changes made to patients' care and treatment have made improvements to their health outcomes.

These are on-going breaches of Regulation 10. We are working and liaising with stakeholders who have plans in place to monitor and improve the quality of the service. We will re-inspect the practice to ensure that required improvements have been carried out.

### Action the service **SHOULD** take to improve

Care plans should be completed for patients where a need has been identified.

Health promotion advice and complaints leaflets should be made available for patients whose first language is not English.

A system for recording the serial numbers of prescriptions pads is introduced to prevent access to medicines in the event of theft of the GPs' prescription pads used for home visits.

An infection control lead responsible for infection control should be identified and appropriate training given.

Recruitment procedures should include an explanation of gaps in employment history.

# Summary of findings

Records are put in place to monitor that oxygen and airway management equipment are in date and fit for purpose.

All staff should receive training in the Mental Capacity Act 2005.

Put in place a business plan identifying their long term plans, vision and strategy to meet the needs of their practice population.

# Dr Om Sharma

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

### Background to Dr Om Sharma

Dr Om Sharma's practice is a single handed GP practice that provides primary medical services to patients living in Nottingham. The practice is based in Greenfields Medical Centre alongside other health care services. The practice has a patient car park with parking available for patients with mobility difficulties. The main entrance to the practice has electronic sliding doors enabling easy wheelchair access over level ground. Part of the reception counter is lowered for use if necessary.

A team of one GP, a part time locum GP, one nurse, a health care assistant, a practice manager, four receptionists and two administrative staff provide care and treatment for approximately 2000 patients. The practice has a proportion of patients from minority ethnic groups and provides care and treatment to asylum seekers. They do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

### Why we carried out this inspection

We inspected this service on 10 October 2014 as part of our new comprehensive inspection programme.

We previously inspected this practice on 23 September 2013, 1 and 10 October 2013 and found that the practice did not meet required standards in safeguarding children and vulnerable adults; management of medicines; safety of equipment; requirements relating to workers; supporting workers and assessing and monitoring the quality of service provision. The practice sent us an action plan telling us what they would do to address these issues.

We returned on 2 July 2014 and found they still did not meet required standards in management of medicines; safety of equipment; requirements relating to workers; supporting workers and assessing and monitoring the quality of service provision. We told the practice to take immediate action to address issues relating to workers and assessing and monitoring the quality of service provision. The practice sent us an action plan informing us how they would address the remaining issues. We returned to the practice on 3 September 2014 and found that required standards had still not been met for requirements relating to workers and assessing and monitoring the quality of service provision.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

### 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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information we held about the practice. We carried out an announced inspection on 10 October, 2014. During our inspection we spoke with one GP, one nurse, one health care assistant, two receptionists, one administrator, the practice manager and six patients. We observed how patients were cared for. We reviewed eight patient comment cards sharing their views and experiences of the practice.

# Are services safe?

## Our findings

### Safe Track Record

There were arrangements in place for staff to report and learn from key safety risks to patients. Staff told us, and we saw training records which demonstrated that staff had attended training, that they had received recent training in identifying and recording significant events. There was a significant events policy in place and staff knew where to locate it for support and guidance. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. They were aware of the most appropriate person to report their concerns to.

Systems were not in place to monitor key safety risks to patients over time. The practice manager showed us four recent significant events that had occurred at the practice. We saw that one had been investigated and learning identified and shared with staff. There had been no investigation into the three remaining significant events. Staff we spoke with told us about an incident that had occurred in the last six months involving a patient who attended the practice with a knife and threatened staff. There was no record of this significant event and no evidence of learning from it. The practice manager told us that the folder containing earlier significant event records had disappeared. An analysis of incidents and significant events over time had not been completed to identify if there were any reoccurring concerns across the service. The new practice manager told us they were aware of the need to monitor significant events and we saw that they had started to complete an audit of the four significant events that they had information about. As the system was not fully operational and effective the practice could not demonstrate their track record of safety. This was an ongoing area of concern.

### Learning and improvement from safety incidents

The practice was open and transparent when things went wrong. The GP, practice manager and staff we spoke with told us there was a blame free culture within the practice.

Robust investigations of significant events were not always carried out. The practice had a system in place for reporting, recording and monitoring significant events. We saw records of significant events that had occurred over the last three months. Records of significant events prior to this had disappeared and there was no audit of them to identify concerns over time. We looked at team meeting minutes

and saw that significant events were discussed with staff and where learning had been identified, this was shared with staff. Staff we spoke with were able to describe some of the learning to us. However, there was no system in place to monitor that any changes made as a result of a significant event had been effective in improving safety for patients.

### Reliable safety systems and processes including safeguarding

Children and vulnerable adults were kept safe from the risk of abuse because there were safeguarding systems in place. Safeguarding policies were in place and staff knew where to find them. There was a safeguarding lead at the practice and staff knew to go to them for advice and support. All staff had received training in safeguarding children and vulnerable adults at a level appropriate to their role. A log containing records of this was made available to us and we saw training certificates. We saw a training certificate that demonstrated the lead GP and practice nurse had completed the higher level three training for safeguarding children. The practice manager had identified that staff were due an update on their safeguarding training and had arranged for this to take place in November 2014.

We asked medical, nursing and administrative staff about their safeguarding training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We saw that safeguarding contact details were easily accessible for staff and displayed in most rooms. We saw that staff safeguarding checks had been carried out for all staff. Where a concern had been raised, we saw that a risk assessment had been completed and appropriate action taken to ensure patients were protected from risk.

Patients were kept safe from the risk of abuse during an intimate examination. There were clearly displayed posters informing patients of their right to have a chaperone present during an intimate examination. We saw there was an up to date chaperone policy in place to ensure patients were protected from potential abuse during an intimate examination. Staff who had received appropriate chaperone training were identified within the chaperone policy. Staff we spoke with were aware of their chaperoning responsibilities.

# Are services safe?

## Medicines Management

Medicines were stored safely. There were appropriate arrangements in place that ensured temperature sensitive medicines such as vaccines were stored safely. There was a policy that clearly outlined how temperature sensitive medicines should be stored to ensure they were fit for purpose. It provided guidance on the action to take in the event of a problem. Staff we spoke accurately described the principles identified in the policy and we saw that they had been carried out. We saw all medicines were in date.

Medicines were administered safely. The practice nurse was qualified as an independent prescriber. They told us they received monthly supervision with the GP at the practice to discuss their prescribing of medicines. They also attended peer review sessions at the local nurse prescribing forum three times a year. We saw that a medicines management audit had been carried out by the community pharmacist which identified that three patients required a review of the medicines. We saw there were systems in place to review their medication and amendments made were needed. Staff responsible for the prescribing of medicines described to us how alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were received and acted upon to keep patients safe from receiving unsuitable medicines.

The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered how staff that generated prescriptions were trained, how changes to patients' repeat medicines were managed and the system for reviewing patients' repeat medicines. However, we saw that clear records for the receiving and distributing of prescription stationery stock were not maintained in line with NHS guidelines. We saw prescription pads were stored in locked cupboards but there was no system in place to identify prescription form serial numbers in the event of theft.

## Cleanliness & Infection Control

On the day of our inspection the practice was clean and tidy. Patients we spoke with told us that the reception area and consulting rooms were always clean. They told us that when appropriate, staff wore personal protective equipment such as gloves. Staff confirmed personal protective equipment was readily available and we saw that it was. There were cleaning schedules in each room demonstrating that the rooms were cleaned daily.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw a certificate that showed legionella testing had been completed in August 2014 to protect staff and patients from the risks associated with the legionella virus. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Systems were not always in place to keep patients safe from the risk and spread of infection. There was an appropriate infection control policy available for staff to refer to but no clear infection control lead for the practice. Staff we spoke with told us they had not received training in infection control so may not be aware of current best practice. We saw that infection control audits had been carried out on 26 June 2013 and 7 October 2014. The first audit had identified a 77% compliance rate but no action plan had been put in place to demonstrate how issues raised would be addressed. The second audit was still in the process of being completed and identified concerns regarding the cleanliness of furniture and carpets.

## Equipment

Patients were protected from unsafe or unsuitable equipment. We saw records confirming that portable appliance testing (PAT) had been carried out on all the electrical equipment at the practice in September 2014. PAT testing ensured electrical equipment was safe to use when treating patients. Records also demonstrated that clinical equipment had been calibrated in December 2013 ensuring it was fit for purpose.

## Staffing & Recruitment

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so considered fit to practice. There was a system in place that ensured health professionals' registrations were in date.

There was a recruitment policy in place which was complemented by a separate DBS policy. Neither of these policies however, identified the need for gaps in employment history to be explained. The practice manager showed us an audit of information kept in each staff members' files. The audit demonstrated that appropriate

## Are services safe?

information was kept in staff files. We looked at the records of six members of staff and saw that appropriate recruitment processes and checks had been carried out. Two of these staff members had been recruited prior to the practice being regulated by the Care Quality Commission so not subject to our regulations at the time of their recruitment. We saw that back dated references had been obtained and risk assessments completed to ensure they were appropriate to provide care to patients. We saw that four members of staff who had been recruited within the last 12 months had been recruited appropriately.

### Monitoring Safety & Responding to Risk

Staffing establishments were reviewed to keep patients safe and meet their needs. There were clearly defined staffing rotas and systems in place to cover annual leave. There was a designated staff member responsible for the rota. Staff told us that they felt there were adequate staffing levels to meet the needs of patients and that they covered each other for annual leave and sickness. There was a business continuity plan in place that outlined how the practice would respond in the event of an increased demand for services, such as in winter, or high staff sickness. The locum GP had informed the practice that they would be leaving the practice. We saw that action had been taken to replace the locum with a new locum GP and that they had been recruited in line with our regulations.

Patients were protected from unsafe premises. We saw records that demonstrated gas equipment had been safety checked in July 2014, the alarm system maintained in August 2014, emergency lighting safety checked in September 2014 and the lift serviced in February 2014. A detailed fire risk assessment had been carried out by the practice in September 2014 and they were awaiting a formal fire risk assessment from the fire service on 18 October 2014.

### Arrangements to deal with emergencies and major incidents

We saw certificates that demonstrated staff were trained in cardiopulmonary resuscitation (CPR). Staff we spoke with confirmed they had received CPR training and appropriately described the care they would provide to patients in the event of a medical emergency. Oxygen, pulse oximeters and airway maintenance equipment for adults and children were available at the practice. We saw there was no system in place to monitor that the oxygen and airway management equipment was in date or fit for purpose. The practice nurse told us they checked there was oxygen in the cylinder but had not checked the expiry date. On the day of our inspection we saw that the oxygen was in date but that two of the oxygen masks were not.

On the day of our inspection clinical staff told us they did not have a defibrillator at the practice. They told us a risk assessment had not been completed to demonstrate how they would keep patients safe in the event of cardiac failure. We saw there was only one type of emergency drug kept at the practice. This was adrenaline, a medicine used to treat severe allergic reactions. Risks assessments had not been completed to demonstrate how the practice would meet the emergency needs of their practice population. For example, there were 107 patients on the practice's diabetic register but there were no medicines available to manage diabetic emergencies. The GP informed us that they carried no emergency medicines in their doctor's bag when they provided home visits. A risk assessment had not been completed explaining how patients would receive appropriate emergency treatment during a home visit. The practice informed us they would assess the needs of their practice population and acquire the appropriate emergency medicines. Within one working day, they confirmed that the appropriate medicines and been ordered. We have not been able to independently verify that these are now in place.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Patients' needs were assessed and care and treatment delivered in line with current evidence based guidance. Clinical staff informed us that they accessed the National Institute for Health and Care Excellence (NICE) guidelines electronically. The aim of these guidelines is to improve health outcomes for patients. Clinical staff described to us how they used these to assess the needs of their patients. For example, the GP told us they had followed the guidance for the changes in the prescription of statins (medicines that can help to lower cholesterol levels in blood). However, there was no evidence that this had been audited to demonstrate that these changes had been effective. Clinicians we interviewed were aware of their professional responsibilities to maintain their knowledge.

The practice referred patients appropriately to secondary and other community care services. National data showed the practice had a high referral rate to ophthalmology. We saw that the practice had carried out an audit of their ophthalmology referrals. The audit identified that most referrals were appropriate due to the type of health issues common to the practice patient population.

Patients with long term conditions received an annual health needs assessment. We saw that the practice kept a register of patients with long term conditions, for example, there were 107 patients on the diabetic register and 80 on the asthma register. We saw that there was a system in place to recall patients with long term conditions for an annual health review. The reviews were carried out by the practice nurse who referred to the GP for support and guidance when needed. We saw that she had received recent extended training in areas such as advanced insulin management, asthma and chronic obstructive pulmonary disease (COPD) management. The nurse had also received training to reflect the needs of the high ethnic population. An example of this was training in reducing the risk of hypoglycaemia (low blood sugar) during Ramadan. A Ramadan Health Guide which had been translated into other languages was available to support the advice given by the nurse to non-English speaking patients.

Patients with a learning disability received an annual health assessment using a health check template. The practice kept a register of patients with learning disabilities which showed there were 10 patients registered with the

practice. Clinical staff met annually with the learning disability co-ordinator to assess all patients with a learning difficulty to ensure they received the most appropriate care and treatment. We saw that the annual health assessments were carried out by a practice nurse who referred to the GP for support and guidance when needed. At the end of the review we saw that the patient was provided with a health action plan which was agreed with them. Information inviting them to the assessment and the health action plan were provided in an easy read format ensuring that the method of communicating with patients with learning disabilities was effective and met their needs.

There were systems in place that ensured babies received a new born and six week development assessment in line with the Healthy Child Programme. The GP carrying out the assessments told us that he had received training in child health surveillance to support him in these assessments. The practice held a register of patients experiencing poor mental health. We saw there were 23 patients on this register and five patients on the dementia register. The GP told us that patients with mental health difficulties received an annual health review. We saw that the GP had recently completed training in the Mental Capacity Act 2005 and were aware of involving patients and relatives in the assessment of their care and needs. Every patient over 75 years had a named GP to ensure continuity of care. There was a multi-disciplinary assessment system in place to review the health needs and care plans of patients who were receiving end of life care.

The practice manager showed us a breakdown of the diversity of the practice patient population. We saw that 43% of patients came from black minority ethnic groups, this was 17% above the NHS Nottingham City Clinical Commissioning Group (CCG) average and 27% above the national average. There were also a high number of asylum seekers registered with the practice. The practice staff informed us that they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. On the day of our inspection we observed two asylum seekers register with the practice. We saw they were inclusively invited to a new patient health check. Staff told us to ensure the health needs of non-English patients were accurately assessed they requested translators to attend the practice.



# Are services effective?

(for example, treatment is effective)

## Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a system in place to frequently review QOF data and recall patients when needed. The practice participated in a benchmarking process with other practices within the CCG. This allowed practices to compare their performance against other practices in the CCG.

The practice had completed a clinical audit but it did not demonstrate how changes to treatment had improved patient health outcomes. The practice showed us one clinical audit that had been completed recently. We saw that the audit had identified two patients with an irregular pulse who were added to the practice's atrial fibrillation register. A second audit cycle had not been completed to demonstrate that if changes had been made they were effective and had improved health outcomes for the patients.

## Effective staffing

Systems had been put in place to ensure new members of staff received an induction to the practice to help them to meet the needs of patients. We saw induction forms for administrative and clinical staff. Staff we spoke with all confirmed they received an annual appraisal. We saw evidence in staff files to confirm appraisals had taken place. We saw certificates demonstrating that all staff had received essential training in safeguarding children and cardiopulmonary resuscitation. Where staff had identified the need for additional training specific to their role or for their professional development, staff told us, and we saw training certificates, that they had been supported to access this. The GP was supported in their revalidation through an appraisal system. Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date with current best practice and fit to practise. We saw the GP had received their last appraisal in January 2014.

## Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. The practice informed us that they held meetings with the Health Visitor to discuss, assess and plan care around safeguarding concerns. One member of staff informed us how they had

alerted the GP about concerns regarding a patient with learning disabilities. They told us the GP contacted the community disability support team and appropriate support was put in place. The practice held multidisciplinary team meetings to discuss the needs of patients with end of life care needs. Minutes from multi-disciplinary meetings between the practice, palliative care and district nurses were not available but outcomes of these meetings were entered directly into patients' records. We saw that the practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed. We saw that the practice worked with the district nursing teams and community matrons to assist in the provision of long term condition monitoring and management of care for housebound patients. An example of this was that the community diabetic nurse visited the practice once a month to discuss any patients of concern. The GP informed us that the practice directed patients experiencing poor mental health to local counselling service such as 'Insight'.

## Information Sharing

There was a system in place for receiving, managing, reviewing and following up the results of tests requested for patients. Reception staff we spoke with clearly understood their role and responsibilities in handling these results and who the results were to be shared with. Blood and X-ray results were received electronically and we saw that they were reviewed by the GP and nurse on a daily basis. The practice nurse demonstrated how text messaging was used to inform patients they required further tests completing. They also demonstrated the task request system used to inform receptionists to follow up patients who needed to be recalled for repeat tests or changes to their care. The practice used special notes to ensure that the out of hours service were also aware of the needs of patients receiving end of life care when the practice was closed.

Hospital discharge, A&E, outpatients and discharge letters were received electronically. Once the practice received the letters they were allocated to the doctor and nurse and followed up in a timely manner.

## Consent to care and treatment

There were mechanisms to seek, record and review consent decisions. We saw there was a consent policy in place at the practice and the GP told us that they recorded consent to treatment in the patients' records. The practice

# Are services effective?

(for example, treatment is effective)

nurse was aware of the need for parental consent for children to receive childhood vaccinations and what action to follow if a parent was unavailable. The GP and nurse we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English or they were hearing impaired.

Some staff we spoke with had not received training in the Mental Capacity Act 2005 but staff did demonstrate some knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We saw examples of how patients with a learning difficulty, mental health difficulty or dementia were supported to make decisions. For example, there were easy read health action plans to enable patients with learning disabilities to understand their planned treatment and care. When patients did not have capacity the staff we spoke with gave us examples of how the patient's best interest was taken into account.

## Health Promotion & Prevention

The practice offered all new patients registering with the practice and patients aged 40-75 years old a health check with the practice nurse or health care assistant. The practice nurse carried out weekly vaccination sessions for children in line with the Healthy Child Programme. We saw that the percentage of children who had received the appropriate immunisations at the appropriate time ranged from 59% - 100%. This was mainly in line with the CCG regional average. The practice staff told us one of their greatest challenges was ensuring that children from Poland received their immunisations. They described the ongoing actions they took to try to address this.

The practice nurse offered healthy living advice and support to patients. This included referrals to weight watchers for patients who needed a weight management programme. All patients with a learning disability were offered an annual physical health check and provided with healthy living advice leaflets in an easy read format.

Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The nurse carried out cervical screening for women in line with national standards and offered screening for Chlamydia for young adults.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 81 patients who took part in the GP patient survey. The GP patient survey is an independent survey run by Ipsos MORI on behalf of NHS England. The evidence from this source demonstrated that patients were satisfied they were treated with dignity and respect but that they did not always feel they were given enough time during consultations. For example, data from the national GP patient survey showed that 86% of patients described their overall experience of this practice as good and 92% of respondents found the receptionists at this practice helpful. These were above the NHS Nottingham City Clinical Commissioning Group (CCG) regional average. However, 74% of practice respondents said the GP was good at listening to them and 76% said the GP gave them enough time. These scores were below the CCG regional average. The practice manager told us they would be carrying out the 'Friends and Family' test in November 2014 to try to understand the reasons for this.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and they were all positive about the service experienced. Patients said they felt the practice offered a good service and described some staff as fantastic. They said staff treated them with dignity and respect. We also spoke with six 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. 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Information from the GP patient survey showed that 72% of patients were satisfied with the level of privacy when speaking to receptionists at the practice. This was above the CCG regional average. We observed staff were careful to follow the practice's confidentiality policy when discussing

patients' treatments in order that confidential information was kept private. There was also a notice informing patients they could request to speak to someone in private if they had confidential issues to discuss. The reception desk was shielded by a glass partition which helped to keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We observed 11 patients in the waiting room and saw no evidence of patients being discriminated against.

The practice had a high ethnic population including asylum seekers. The practice informed us that they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. We saw there were information leaflets and posters available for patients in vulnerable circumstances displayed in the reception area. These included bereavement support and support services for patients with mental health difficulties. We saw that leaflets were only available in English so did not meet the needs of the 43% of patients from black minority ethnic groups or patients from other non-English speaking countries. Patients we spoke with on the day of our inspection told us they were referred to other services for support such as counselling, talking therapy and New Leaf (a smoking cessation service).

### Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed patients did not always respond positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 67% of practice respondents said the GP involved them in care decisions and 75% felt the GP was good at explaining treatment and results. Both these results were below the CCG regional average. The practice had not carried out its own patient satisfaction survey but had arranged a meeting for 6 November 2014 to establish a patient participation group (PPG) to seek out patient views and to try to understand

## Are services caring?

the reasons behind these low results. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive.

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

Every patient over 75 years of age had a named GP to ensure continuity of care. The practice had signed up to the enhanced service for the avoidance of unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. To meet this objective a list of elderly patients had been generated by the practice and a care plan template provided by the CCG. No unplanned admission care plans had been completed however on the day of our inspection.

The practice had seven patients on their end of life register. The GP told us that monthly multi-disciplinary meetings between GPs, the community matron, palliative care and district nurses were held to discuss the care of these patients and that care plans were put in place. There were no minutes available from these meetings but we saw that details were entered in to patients' records by the GP or community matron. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

There were 10 patients on the practice's learning disability register. We saw that annual health reviews were carried out for patients with learning disabilities using a health check template. At the end of the review the patient was provided with a health action plan which was agreed with them. The health action plan was provided in an easy read format so that patients understood it. There were 23 patients on the practices' register for patients with mental health difficulties. There was a system in place to ensure that patients with mental health difficulties received an annual health review. We saw there was a care plan template to enable GPs to plan the care for patients with mental health difficulties. Patients with long term

conditions, such as diabetes or high blood pressure were recalled for their annual health review on their birthday and were provided with an extended appointment at a time convenient for them. Staff told us how they booked interpreters for patients who did not speak English or had a hearing impairment. This enabled them to be involved in decisions about their care.

### **Patient/carer support to cope emotionally with care and treatment**

The GP patient survey information we reviewed showed patients were not always positive about the emotional support provided by the practice. For example, 76% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern with a score of 69% for nurses. These results were below the CCG regional average. However, the six patients we spoke with on the day of our inspection all spoke positively about the care they received from the GP and nurse. Eight comment cards we received were also consistent with this survey information. For example, patients described the care they received as very good. The practice manager told us they would discuss these results with the PPG when it had been established.

Notices in the waiting room signposted patients to a number of support groups and organisations such as bereavement support, carer's support and counselling. However there was little information available on the practice's website. The practice's computer system alerted GPs if a patient was also a carer. We were shown a carers identification and referral form for patients who looked after someone who was ill, frail, disabled or had mental health difficulties. The information from this form was used to update patients' records. We asked staff where they sent the completed referral forms to ensure carers received the support they requested. They told us that Nottingham County Council had a self-referral scheme for carers, although sometimes they contacted them on behalf of the patient. The form was misleading to patients because it clearly stated that it was a referral form for carers to receive support. It did not make it clear that they would need to self-refer or who they would need to self-refer to.

Staff told us families who had suffered bereavement were called by their GP. The GP told us that following this call they offered a home visit if the patient needed it and signposted patients to a support service.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. No formal assessment of the overall needs of the practice population had been carried out. It was clear though through discussions with clinical staff and the practice manager that the needs of the practice population were understood and systems were in place to address some of the identified needs. The practice worked with the NHS Nottingham City Clinical Commissioning Group (CCG) using e-health scores, a risk assessment tool, to identify patients who had high risk needs. This helped GPs to detect and prevent unwanted outcomes for patients by allocating a risk score dependent on the complexity of their disease type or health needs. We saw evidence that 30 patients had high e-health scores and that monthly meetings were held between the GP, community matron, district and palliative care nurses. Multi-disciplinary care services were put in place to ensure that patients received continuity of care across all agencies.

A new practice manager had recently been employed by the practice following a period of temporary practice managers. We saw that the new practice manager had plans in place to establish a patient participation group (PPG) to look at suggestions for improvements and make changes to the way the practice delivered services. There had been very little turnover of other staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

The practice had achieved and implemented the gold standards framework for end of life care. They had an end of life care register and had regular internal as well as monthly multidisciplinary meetings to discuss patients and their families care and support needs. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register to seven. The practice worked collaboratively with other agencies and shared information with out of hours services through special patient notes to ensure good, timely communication of changes in care and treatment.

### Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. One member of staff told us how they had used the Homeless Forum and other agencies to provide support for a homeless patient with mental health difficulties. They told us that the GP had stayed with the homeless patient until support had arrived.

Home visits and longer appointments were available when necessary for patients with long term conditions. Appointments were available after school hours for children and young people, and there were appointments available until 7.30pm on Monday evenings for working age patients. There was evidence that the practice worked in partnership with community nursing services and mental health services to understand the needs of the most vulnerable in the practice population. The practice had an open policy to care for asylum seekers and we observed they were offered new patient interviews when they registered with the practice. The GP informed us that they directed asylum seekers to support groups in the area.

Patients with learning disabilities were provided with an annual health review and health advice leaflets in an easy read format to help them to understand their health care needs. The practice held registers of patients who may be living in vulnerable circumstances, had a long term condition, a learning difficulty or suffered mental health difficulties. There was a system for flagging these needs in individual records.

### Access to the service

The practice opened from 8am till 6pm weekdays excluding Thursday afternoons when it was closed. GP appointments were available weekdays from 10.30am to 12pm and 4.30pm to 6pm. There was a late night surgery until 7.30pm on Monday evenings for working age patients. There were no GP appointments Wednesday mornings. We asked the GP what arrangements they had in place in the event of a medical emergency between 8am and 10.30 am, Wednesday mornings and Thursday afternoons when there was no GP cover. They told us out of hours cover was available Thursday afternoons and the practice nurse was



# Are services responsive to people's needs?

(for example, to feedback?)

available before 10.30am each morning and Wednesday mornings. They also told us there was an agreement with the other practice based in the medical centre to provide emergency GP cover if needed.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book online appointments with the practice nurse. Online appointments were not available for the GP. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were informed how to access out of hours services via posters in the waiting room and details were on the practice website. If patients called the practice when it was closed their call was redirected to the out of hours service.

Patients told us they were satisfied with the appointments system. This was supported by data from the national GP survey which demonstrated that 86% of patients were able to get an appointment to see or speak to someone the last time they tried. This was above the CCG regional average. Appointments were bookable one month in advance via telephone or face to face. Text messages were sent to remind patients of their appointment times. Patients confirmed that they could see a doctor on the same day if their need was urgent. Formal audits of appointments had not been carried out to assess if the appointment system met the needs of patients. The practice manager informed us this is an area they want to review. Staff were aware that some patients did not understand the difference between urgent and non-urgent appointments. They told us they had cards which they gave to patients explaining what an urgent appointment was and that the GP educated patients during their appointment. Telephone consultations were provided by the practice nurse who was also a nurse practitioner.

The premises and services had been adapted to meet the needs of patients with disabilities. We saw that there was a patient car park with parking available for patients with mobility difficulties. The main entrance to the practice had electronic sliding doors which enabled easy wheelchair access over level ground. Part of the reception counter was lowered for use if necessary.

The practice had a 21.6% white British population, 43% of patients came from black minority ethnic groups and the remainder of the practice population from other countries. To support patients who could not speak English, the practice had access to a pre-bookable translation service and a GP who spoke Urdu.

## Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. We saw there were patient complaint leaflets available in the reception area and information of how to complain on the practice website. The practice manager informed us they were exploring ways of getting the complaints leaflet translated into other languages to reflect the needs of the local population. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months. We found that a letter of response had been sent to the complainant of the first complaint within three working days. However, there was no invitation offering the complainant the opportunity to discuss their concern further. We saw that the complaints policy had been reviewed in May 2014 and changes to the designated complaints manager made. The second complaint was dealt with by the new designated complaints manager. On this occasion we saw that the complaint had been dealt with appropriately. The practice manager showed us their annual complaints review. We saw specific training had been identified in response to the learning from one of the complaints.

# 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

Staff were aware that the short term vision for the practice to improve health outcomes for patients was to address key areas of concern identified in our previous inspections. A strategy was being developed to determine how this was to be achieved and what the practice's long term vision would be. There was no business plan in place for the development of future services.

We spoke with the new practice manager who had been in post one month. They told us that they recognised the practice needed clear leadership and vision. Through conversations with the practice manager we found them to be insightful into the improvements required at the practice and they were able to demonstrate how they would achieve this. The practice manager and GP told us they had daily meetings to develop their strategy. Since being in post, the practice manager had introduced a quality assurance policy. They described to us how they used the policy to identify quality assurance actions they needed to take to determine their vision and strategy for the provision of good quality care. We saw the practice manager had identified key areas which included infection control; staff training; recruitment; recording of significant events and audit. They described to us the system they would use to monitor progress of these key areas and that they had used team meetings to share this information with staff. The five members of staff we spoke with were aware of these key areas of concern and confirmed they had been discussed at team meetings.

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's internal computer system. Staff we spoke with were able to demonstrate to us how they accessed these policies. We looked at 11 policies and saw that they had been reviewed in the last 12 months. The practice manager informed us that now they were in post they planned to review all the policies to ensure they met the needs of the practice.

The practice manager told us they held governance meetings with the GP each day that they worked. There were no recorded minutes from these meetings for us to

view. The practice held monthly team meetings and we saw minutes from these meetings. The last meeting was held on 1 October 2014. We saw that governance issues were discussed with staff at this meeting.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing slightly below national standards scoring 94.5 out of a possible 100 points.

Clinical and service wide audits had been carried out but where issues had been identified action had not always been taken. The practice showed us one clinical audit that had recently been completed. We saw that the audit had identified two patients with an irregular pulse who were added to the practice's atrial fibrillation register. A second audit cycle had not been completed to demonstrate that if changes had been made they were effective and had improved health outcomes for the patients. We looked at four service wide audits, these included medicines management, infection control, complaints and an audit of staff records. We saw that where issues had been identified action plans had not always been put in place to demonstrate how the findings of this audit could be used to improve the quality of care for patients.

The practice had limited arrangements in place for identifying, recording and managing risks. We saw that fire and legionella virus risk assessments had been completed. There was also a business continuity plan in place that had assessed the risk of issues such as loss of domestic services and staffing shortages. We saw that action plans had been put in place to identify how these would be managed. There was no risk log which addressed a wide range of potential issues, such as Control of Substances Hazardous to Health (COSHH) or a robust analysis of significant events over time. Risk assessments had not been completed to demonstrate how patients would be kept safe in the event of a medical emergency when there was only one type of emergency drug and no defibrillator.

### Leadership, openness and transparency

During our previous inspections we saw that staff were not always sure who to go to for support and there was no clear

# Are services well-led?

Requires improvement 

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

leadership structure. At this inspection we saw that a leadership structure was in the process of being developed. For example, the GP was the lead for safeguarding and complaints and the practice manager was the lead for governance and training. There was no identified lead for infection control. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw minutes from monthly team meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction, training and recruitment policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the national GP patient survey and complaints. We saw that the practice had used the complaints to identify the need for additional training for staff. The practice manager told us they recognised that only 62% of respondents to the national GP patient survey would recommend the practice to someone new to the area. This was below the average for their regional Clinical Commissioning Group (CCG). The practice manager told us they would be instigating the Friends and Family Test at the end of November 2014 to try to understand why this was.

The practice did not have a patient participation group (PPG) in place. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The practice manager told us they recognised that the practice needed to improve its communication with patients to enable them to be involved in making the correct decisions about their care. They told us they had arranged a PPG meeting but no-one turned up. We saw that a new meeting had been arranged for 6 November 2014 and the practice manager had proactively encouraged patients to attend.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with understood what whistleblowing was and why it was important in keeping patients safe. Whistleblowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected.

## **Management lead through learning & improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff training files and saw that staff had received training specific to their role. We saw that they had received a recent appraisal which identified their training needs. Staff told us that the practice was very supportive of training.

Robust reviews of significant events and other incidents were not always carried out. We saw records of four significant events that had occurred over the last three months. Only one of them had been investigated and so learning from the remaining three had not occurred. Staff we spoke with told us about an incident that had occurred in the last six months involving a patient who attended the practice with a knife and threatened staff. There was no record of this significant event and no evidence of learning from it. The practice manager told us that the folder containing earlier significant event records had disappeared. An analysis of incidents and significant events over time had not been completed to identify if there were any reoccurring concerns across the service. The new practice manager told us they were aware of the need to monitor significant events and we saw that they had started to complete an audit of the four significant events that they had information about.

There had been some improvement in assessing and monitoring the quality of the service provision since our last inspection. However, there were still concerns regarding the analysis of significant events, the lack of risk assessments to keep patients safe from the risk of harm and the failure to seek the views of patients. We met with stakeholders on 28 October 2014 to discuss our concerns



# Are services well-led?

Requires improvement



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

and to identify ways to support the practice in the changes they need to make. We will continue to monitor the situation and will re-inspect the practice to ensure that the required improvements have been carried out.