

Tinkers Lane Surgery

Quality Report

Tinkers Lane
Royal Wootton Bassett
Wiltshire
SN4 7AT

Tel: 01793 852131

Website: www.tinkerslanesurgery.co.uk

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tinkers Lane Surgery on 23 March 2015. Overall the practice is rated as **REQUIRES IMPROVEMENT**.

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

- Urgent appointments were usually available on the day they were requested. However, patients said there were waits of up to two weeks for non-urgent appointments, there was difficulty getting through to the practice when phoning to make an appointment and waits of up to 40 minutes after appointment times.
- Few clinical audits had been carried out. There was limited evidence to demonstrate that audits were driving performance to improve patient outcomes.
- Data showed patient outcomes for March 2015 demonstrated an improvement from 2013/14 which had been overall below average for the local Clinical Commissioning Group.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to some recruitment checks.
- 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 and easy to understand.
- The surgery has worked with Carers Support Wiltshire in recent years, obtaining their Gold Award, followed by Gold Plus and this year was working to achieving the new 'Gold' award. The practice held two to three carers' clinics a year and carers' events twice a year.
- A number of staff were 'dementia friends' and there were plans for more staff to undertake the training.

Summary of findings

Importantly, the provider **MUST**:

- Ensure accurate records of staff training are maintained
- Maintain accurate records of all meetings regarding patient care and treatment.
- Ensure patient access to appointments and prescription services are improved and maintained.
- Ensure policies, procedures and guidance are updated to enable staff to carry out their role.
- Ensure there is an effective system for monitoring patients prescribed high risk medicines.
- Ensure all safeguarding measures are in place to protect patients at risk. Including safeguarding meetings, training and policy and procedure.

In addition the provider **SHOULD**:

- Ensure the plan to undertake staff appraisal is implemented.
- Develop processes to enable management to lead through learning
- Develop and monitor processes for demonstrating the achievement of quality care standards for the management of common long term conditions.
- Ensure there are risk assessments for emergency medicines not held in the practice.
- Develop an audit schedule to ensure clinical audit is carried out regularly.

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 providing safe services. GP safeguarding training records did not evidence they had undertaken the appropriate training in line with national guidance and practice policy. The systems and processes to address safeguarding risks were not implemented well enough to ensure patients were kept safe. For example, formal meetings with health visiting staff did not regularly take place and records of meetings were not kept. Some patients prescribed high risk medicines had not been monitored before continuing to prescribe further medicines. Lessons were learned from complaints and incidents and communicated to support improvement. Information about health and safety risks such as cleaning and waste management, emergency contingency planning was recorded, monitored, appropriately reviewed and addressed. Overall there were enough staff to keep patients safe and they had recently appointed a deputy practice manager.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. The number of patients recalled for reviews for long term condition was below the local average. Multidisciplinary working was taking place but was generally informal and record keeping of meetings was limited. The practice had developed an action plan in January 2015 to secure immediate improvements for all the areas identified. Data showed patient outcomes in March 2015 (QOF) had improved from the results in 2013/14 which were at or below the average for the local Clinical Commissioning Group. We found reference to and knowledge of national guidelines was consistently applied to patient treatment and support.

Requires improvement



Are services caring?

The practice is rated as requires improvement for providing caring services. Generally most staff were described as respectful and kind. In particular the nursing staff were identified as supportive, friendly and caring. This was supported by feedback from the GP National Patient Survey 2013/2014 which indicated 87% of the practice respondents said the last nurse they saw treated them with care and concern. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care

Requires improvement



Summary of findings

and treatment. Information to help patients understand the services was available and easy to understand. However, overall patient satisfaction with the practice was low compared to Wiltshire Clinical Commissioning Group (Wiltshire GP Patient Survey Report 2014).

The surgery has worked with Carers Support Wiltshire in recent years, obtaining their Gold Award. The practice held two to three carers' clinics a year and carers' events twice a year.

Are services responsive to people's needs?

The practice is rated as requires improvement for being responsive to people's needs. The practice had reviewed the needs of its local population, and had an action plan to secure improvements for all the areas identified. For example, the recruitment and interview date for an additional GP had been arranged. A schedule for improving multidisciplinary meetings had been developed and the nurse triage system review was scheduled for completion by the end of April 2015.

Urgent consultations with the nurse and GP were available on the same day. However, patients had waits of up to six weeks for a routine appointment with one particular GP and two to three weeks for a non-urgent appointment with any GP. We found that it was difficult to get through to the practice by telephone to make an appointment although patients could book via the practice website. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised.

Requires improvement



Are services well-led?

The practice is rated as requires improvement for being well-led. The practice did not consistently lead through learning. There was inconsistent recording of meeting minutes with regards to patient care which would have acted as a resource for staff unable to attend the meetings. Staff involved in significant events, complaints and incidents did not participate in meetings where action and learning took place.

The practice was aware of the challenges to the practice and was proactive in their management. There was a clear leadership structure and overall staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings although some policies required updating. There were some systems in place to monitor and improve quality and identify risk. The practice proactively

Requires improvement



Summary of findings

sought feedback from staff and patients, which it had begun to act on. Although staff had not had an annual appraisal since 2013 there were informal opportunities to discuss their performance and training needs.

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 provider was rated as requires improvement for this population group. Care and treatment of older people reflected national guidance. Nationally reported data (QOF 2015. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually) showed that outcomes for patients for conditions commonly found in older people such as dementia and stroke had improved from the 2013/14 results which had been equal or below the local Clinical Commissioning Group average.

The practice offered home visits and support to three local care homes including a weekly 'ward round' at one home.

The practice delivered a range of enhanced services (services offered to meet local and national priorities and agreements). Data we reviewed demonstrated 84% of over 70's identified as vulnerable and at risk of admission to hospital had care plans to support their care and treatment. The practice held a register of patients requiring palliative care support and met every two months with the multidisciplinary team to enable appropriate care.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for this population group. Nursing staff had lead roles in chronic disease management such as diabetes and asthma and patients at risk of hospital admission were identified as a priority.

85% of patients with a long term condition identified as at risk of admission to hospital had care plans to support their care and treatment. Longer appointments and home visits were available when needed. Patients were offered a structured annual review to check their health and medication needs were being met although we noted these were relatively low compared to the CCG average. However, there was a comprehensive recall system in place to review patients. For those people with the most complex needs, the named GP worked with a care co-ordinator who liaised with relevant health and care professionals to deliver a multidisciplinary package of care based on a person centred care plan.

Requires improvement



Summary of findings

Families, children and young people

The provider was rated as requires improvement for this population group. Immunisation rates were equal to or above the Clinical Commissioning group average.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We discussed examples to confirm staff understood issues regarding consent and confidentiality when supporting young adults and children who were Gillick competent. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice offered free, confidential contraceptive and sexual health advice to young people. Family planning services were available for women including the fitting of intrauterine devices (contraceptive coils). QOF data (March 2015) demonstrated 100% achievement with regards to cervical screening.

Requires improvement



Working age people (including those recently retired and students)

The provider was rated as requires improvement for this population group.

The practice provided monitoring of some medical conditions to avoid the need to attend hospital for the investigations. These included blood tests for patients on blood thinning medicines and 24hour electrocardiogram (to assess heart rhythm) monitoring. Patients were able to book an NHS health check with the practice or the local chemist as part of a local partnership initiative. The practice offered appointments up to 7.30pm each Wednesday and Thursday.

Practice appointments could be booked online, by telephone or a visit and up to four weeks in advance to enable patients to plan around work commitments. All on the day urgent appointments for minor illness were triaged by the practice nurse who offered face to face or telephone consultations. This facilitated patient access to support and treatment when GP appointments were difficult to obtain. Patients were able to access health information via the practice website.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated requires improvement for this population group. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, GP safeguarding training records

Requires improvement



Summary of findings

did not evidence they had undertaken the appropriate training in line with national guidance and practice policy. The systems and processes to address safeguarding risks were not implemented well enough to ensure patients were kept safe. For example, formal meetings with health visiting staff did not regularly take place and records of meetings were not kept.

The practice supported patients with learning disability and dementia resident in three care homes. The practice had carried annual health checks for people with a learning disability and offered flu immunisation for the people in the care homes.

The practice had earned an award for their work with carers. They held carers' clinics and at least one carers' event each year.

People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for patients experiencing poor mental health. The practice had improved the regular monitoring of patients treatment and support needs. For example, the assessment and monitoring of patients with depression (QOF 2013/2014) had improved from 32% achievement of minimum standards to 75% (March 2015). The practice had identified further work was required in this area.

Dementia reviews were undertaken by nursing staff in partnership with the GPs. Longer appointments and home visits were available for patients when needed. A number of staff were 'dementia friends' and there were plans for more staff to become involved.

LIFT psychology sessions were held twice a week at the practice for patients with common emotional, communication and mental health difficulties such as anxiety.

Requires improvement



Summary of findings

What people who use the service say

On the day of the inspection we spoke with eight patients from the practice two of whom represented the patient participation group. We looked at fifteen patient comment cards, the practice survey (2014), the GP National Patient Survey 2014 and three comments (2014) on the NHS Choices website.

Overall, patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients had mixed responses to the care and treatment they received. This was confirmed by the GP National Patient Survey (2014) where 55% of respondents described their overall experience as good. Generally most staff were described as respectful and kind. In particular the nursing staff were identified as supportive, friendly and caring. This was supported by feedback from the GP National Patient Survey 2014 which indicated 76% of the practice respondents said the last nurse they saw treated them with care and concern. Patients we spoke with felt their privacy and dignity were respected. They gave examples of how the practice had improved or were planning to change the layout of the reception area to enhance privacy and confidentiality.

Patients' feedback told us patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. Feedback from the GP National Patient Survey 2014 indicated 71% of respondents said the last nurse they saw was good at explaining tests and treatments which was below the CCG average of 80%.

Most patients' negative comments concerned the challenges of making a routine appointment, waiting

times, getting through to the practice by telephone and the length of time taken for the issuing of repeat prescriptions. Only 38% of patients in the GP National Patient Survey (2014) said their experience of making an appointment was good or very good. Generally this comment was reflected in other patient feedback we received. Patients requesting to see a GP for a routine appointment told us they frequently waited up to two to three weeks and up to six weeks for one particular GP of choice. Some patients indicated it was difficult to get through to the practice by telephone to make an urgent appointment particularly when the practice first opened in the mornings. This was supported by information from the GP National Patient Survey 2014 where 46% of respondents found it easy to get through by telephone. We spoke with three patients who told us coming to the practice was the only way to book a routine appointment due to the difficulties of telephone access. Patients told us they appreciated they were able to book appointments up to four weeks in advance which helped with planning work commitments.

Three patients we spoke with were concerned about the wait after their appointment time. This was reflected in four responses from the practice patient survey 2014, patient participation group meeting 2015 and the GP National Patient Survey (2014) feedback.

Patients we spoke with were aware of the complaint process and expressed confidence in the practice to address concerns when they were raised. There were 32 written and verbal complaints from April 2014 to March 2015.

Areas for improvement

Action the service MUST take to improve The provider MUST

- Ensure accurate records of staff training are maintained
- Maintain accurate records of all meetings regarding patient care and treatment.
- Ensure patient access to appointments and prescription services are improved and maintained.

- Ensure policies, procedures and guidance are updated to enable staff to carry out their role.
- Ensure there is an effective system for monitoring patients prescribed high risk medicines.
- Ensure all safeguarding measures are in place to protect patients at risk. Including safeguarding meetings, training and policy and procedure.

Summary of findings

Action the service SHOULD take to improve

The provider SHOULD:

- Ensure the plan to undertake staff appraisal is implemented.
- Develop processes to enable management to lead through learning
- Develop and monitor processes for demonstrating the achievement of quality care standards for the management of common long term conditions.
- Ensure there are risk assessments for emergency medicines not held in the practice.
- Develop an audit schedule to ensure clinical audit is carried out regularly.

Tinkers Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor.

Background to Tinkers Lane Surgery

As part of the inspection we visited Tinkers Lane Surgery, Tinkers Lane, Royal Wootton Bassett, Wiltshire SN4 7AT.

Tinkers Lane Surgery provides primary care services to patients resident in the town of Royal Wootton Bassett. The practice is purpose built with all patient services located on the ground floor of the building. The practice has an expanding patient population of 8,758 of which the highest proportion are of working age. The practice has had a number of key staff changes during the last two years which staff described as having an impact on the morale of staff and the smooth running of the practice. The practice has recently appointed a practice manager following staff sickness of over a year.

The practice has a total of four GPs. Two are partners and two salaried GPs. There are seven nursing staff, one phlebotomist, a practice manager, and reception/administration staff. Most staff work part-time.

The practice is open 8.30 am – 6.15 pm Monday, Tuesday and Friday and late opening until 7.30pm on Wednesdays and Thursdays. The practice has opted out of the Out of Hours primary care provision. This is provided by another provider MEDVIVO.

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 patients' needs?
- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health (including patients with dementia)

Detailed findings

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the Wiltshire Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 23rd March 2015. During the inspection we spoke with three GPs, the practice manager, six nursing staff, administration and reception staff. We spoke with eight patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we were told there was a case of mistaken identity and the wrong patient had been prepared for a specific blood test. This was identified immediately, reported and the patient informed and monitored for any ill effects. Action was implemented to prevent the specific circumstances which triggered the error happening again.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events and complaints were a standing item on the weekly practice meeting agenda. However staff involved in significant events, complaints and incidents did not participate in meetings where the action and learning took place. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. We tracked patient incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a patient had had tripped in the practice car park

resulting in resurfacing on the car park. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were clear about the process for accessing notifications that were relevant to the care they were responsible for. They also told us alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had some systems to manage and review risks to vulnerable children, young people and adults. The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. We looked at training records which showed that not all staff had received relevant role specific training on safeguarding. For example two doctors had not completed safeguarding children/vulnerable adults training. One of the safeguarding leads had not completed level three safeguarding children training in line with national guidance. We asked members of medical, nursing and administrative staff about their understanding of safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

There was a system to highlight vulnerable patients and their families on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice did not meet regularly with other health and social care professionals to review the support patients at risks and their families required although there were informal communication processes with health visitors who were based at the practices.

Are services safe?

There were notices advising patients about requesting a chaperone in all patient areas. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff did not act as a chaperone if nursing staff were not available as the practice did not undertake disclosure and barring checks on this group of staff.

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. We noted a record of medicines stocked was kept by the practice to demonstrate how they were being used.

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

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions. Only nurses recorded on the Nursing and Midwifery Council register (the body holding the licenses for all nurses and midwives) administered medicines prescribed under patient group directions (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) medicines. We saw from induction records registered nurses did not give adult immunisations until they had received training and had been assessed as competent by more experienced staff. Only the lead nurse administered childrens' immunisations. Staff told us they were up to date with training to administer vaccines.

We reviewed the system for monitoring high risk medicines. We found there was a robust system to monitor patients taking blood thinning medicines. Blood tests and the results were available via the practice with a prompt review by the GP. The practice had undertaken an audit of patients prescribed methotrexate (a medicine to treat conditions like rheumatoid arthritis). The audit also identified those patients requiring blood tests before further prescriptions

were issued. However, we found from two of two patient records we reviewed the necessary actions to recall patients were not followed through and prescriptions had been issued.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The electronic repeat prescribing procedure protected patients from risk. The practice had reviewed the prescription requests process following the change of the electronic records system. They were in the process of reviewing the protocol to enable patient prescriptions to be issued efficiently and effectively. There were systems in place to identify when patients required a medicines or health review before further prescriptions were issued.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who provided advice on the practice infection control issues. Infection control audits were completed every four months. The most recent audit was in March 2015 and the practice had 88% compliance. Improvements were identified for action and were completed in line with the action plan.

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

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

The practice had undertaken a legionella audit in March 2013. A review date for 2015 was scheduled.

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment maintenance logs and other records that demonstrated equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We looked at three staff records. Appropriate recruitment checks had been undertaken prior to employment. References, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) were recorded. Staff explained the interview process and we saw completed interview schedules to demonstrate the process for selecting candidates.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to ensure that enough staff were on duty. Locum staff were used to cover GP annual leave. Nursing and administrative staff either covered each other's annual leave or the practice occasionally used locum staff.

Staff told us although it was often very busy there were usually enough staff to maintain the smooth running of the practice and enough staff on duty to keep patients safe. We observed there was one receptionist on the reception desk at any one time which resulted in patients queuing to speak to the receptionist at busy times. The practice manager told us there were usually two reception staff on Monday mornings as was a busy time. Patients had access to the self-check in system for appointments to alleviate the wait for the receptionist.

At the time of the inspection both GP partners and one of the salaried GPs worked four days a week (eight sessions). The other salaried GP worked five sessions a week. The practice used locum GPs to cover any shortfall in GP session cover.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and training records demonstrated some staff attended health and safety training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. All staff undertook training annually. We were told arrangements were made for new staff to attend basic life support training at another practice if they had missed the training at the practice. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We were given an example of how staff had successfully administered emergency treatment to a child who had a respiratory arrest and who required transfer to hospital.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. However, we noted atropine (a medicine used to improve the heart rate and recommended as an emergency medicine if necessary during contraceptive coil insertion) was not available and there was not a risk assessment to evaluate the potential risk to patients. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Are services safe?

the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. We saw there was forward planning in place to cover staffing levels over the forthcoming holiday period.

The practice had records to demonstrate there had been a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff 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 other research evidence. For example, NICE guidelines on the management of patients with asthma. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the use of care pathways and care plans for patients with long term conditions such as respiratory disease. Nursing staff were able to explain how they decided on the most appropriate wound care treatment by reference to NICE guidance and how the management of asthma was in line with best practice evidence. The GPs told us they lead in some areas of specialist clinical areas such as diabetes. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Nursing staff we spoke with were open about asking for and providing colleagues with advice and support. We looked at data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing. We saw data which demonstrated the prescribing of cephalosporin and Quinolone (antibiotics) had improved with a reduction from 10% to 5.3% (expected 6%) in November 2014.

The practice used a risk stratification tool to identify 2% of the most vulnerable patients on the practice list. We saw 85% of these patients had a personalised care plan to assist in their support and treatment to avoid admission to hospital. For those people with the most complex needs, the named GP worked with a care co-ordinator who liaised with relevant health and care professionals to deliver a multidisciplinary package of care based on a person centred care plan.

We were told recalls for chronic disease clinics were delayed for a period in 2013 due to nurse staffing levels. However, this had now been addressed and training provided. This meant that current performance in terms of reviews was at 75% for patients with asthma, 73% for patients with COPD and over 66% for patients with diabetes. This was below the CCG average for COPD and

diabetes (QOF 2013. CCG COPD 90%). Some patients with lung conditions were also sign posted to workshops held at the local community hospital to self-manage their condition.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of cancer patients.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to identify patient risk and service improvement.

The practice showed us three audits undertaken in 2014 one of which demonstrated changes to treatment or care were made where needed which had then been repeated to ensure outcomes for patients had improved. A nursing audit reviewed the management of children aged between five and 12 years old diagnosed with asthma and prescribed inhalers. Results from the first audit cycle demonstrated that a number of patients prescribed with inhalers were not recorded on the asthma register. In addition the audit identified children seen by the out of hours service for asthma related issues were not consistently followed up by the practice. Guidance for GPs and triage nurses regarding the criteria for patient reviews by the lead respiratory nurse were developed. The audit was repeated and demonstrated the asthma register accurately represented the children receiving treatment. The data demonstrated children newly prescribed inhalers or those presenting with persistent coughs to the nurse triage service were reviewed by the lead respiratory nurse.

Are services effective?

(for example, treatment is effective)

Patients seen by the Out of Hours service were also followed up by the lead nurse which resulted in a change of treatment for one child who had presented with an acute exacerbation of asthma.

We looked at an audit regarding the monitoring of patients on methotrexate (a medicine used in the treatment of rheumatoid arthritis). The practice had identified those patients who required regular blood tests as part of a medicines review before further prescriptions were issued. However, on the day of the inspection we found from two patient records the necessary actions to recall the patients were not followed through and prescriptions had been issued. The practice sent updated information after the inspection which demonstrated they had updated the record identifying the status of each patient's blood results. However, the system for recalling patients had not been clarified.

The third audit was a review of 21 unplanned admissions of patients over the age of 80 years undertaken over a three month period in 2014. The data described the reasons for admission, previous contact with health and social care providers and whether they had a care plan. The review was repeated six months later. The data demonstrated of the 15 patients from the original group there had been five admissions. The outcome of the audit identified one patient who had an emergency admission did not have a care plan in place and was referred to the Care Coordinator.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The QOF data for this practice showed that QOF achievement (March 2015) had improved from data collected in 2013/2014 which had not consistently performed in line with local and national standards. The QOF overall achievement (2015) stood at 86% compared to 79.4% in 2013/14. For example, 100% of patients with a learning disability had an annual review, monitoring of patients with epilepsy was 100% (March 2015) compared to 26.4% in 2013/14. QOF data for a range of long term conditions had improved. The practice had achieved 95% of the minimum standards for patients diagnosed with chronic obstructive respiratory disease (2015) compared to 87% (2013/14), 87% of the minimum standards for patients with hypertension (2015) compared to 36% (2013/14). The monitoring of patients with heart disease and diabetes remained at a similar level 98% and 84% respectively).

We reviewed three records with the GPs because QOF data (2013/14) showed patient outcomes were below average for the local Clinical Commissioning Group. The patient records we look at were comprehensively completed. Care plans for patients with long term conditions were detailed and provided sufficient information to support care and treatment. Also documented were discussions regarding their preferred place of death and resuscitation wishes.

There was a protocol for repeat prescribing which was in line with national guidance. This protocol had recently been reviewed and clarified the necessity for staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked that routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. However, the evidence for reviewing patients prescribed methotrexate demonstrated repeat prescriptions were issued despite some patients requiring an essential blood test before reissuing the prescription.

The evidence we saw from discussions and review of three patient electronic records confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the Gold Standards Framework for end of life care. It had a palliative care register and had bi-monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice supported patients experiencing poor mental health by regular monitoring of their treatment and support needs. QOF data demonstrated there had been significant improvement in the practice monitoring of patients experiencing depression (32.3% in 2013/2014 to 75% in 2015). The practice had highlighted this as requiring further improvement and had a strategy to address the issues.

Dementia reviews and memory assessments were undertaken by nursing staff in partnership with the GPs. The practice nurse had an hour to undertake tests such as urinalysis and an electrocardiogram and to complete comprehensive questions developed to assess a patient's memory. The patient was then referred to the GP to

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(for example, treatment is effective)

evaluate the results and determine whether further assessment was needed. Longer appointments and home visits were available for patients with dementia when needed. A number of staff were 'dementia friends'.

LIFT psychology sessions were held twice a week at the practice for patients with common emotional, communication and mental health difficulties such as anxiety.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Practice nurses were expected to perform defined duties and told us they were trained to fulfil these duties. For example, administration of vaccines, cervical smears and some extended roles such as asthma and diabetes reviews. We reviewed staff training records and found they were not well maintained or updated regularly.

The practice could not consistently evidence that all mandatory training and staff continuing professional development training had been completed. Evidence such as certificates were not available to corroborate training undertaken. We could not be assured from training records the nurses mainly responsible for immunisations had updated in line with national guidance.

However, we saw from nursing team meeting minutes (February 2015) staff had recorded the training/updates that had been attended or were imminent and these confirmed what staff had told us. This included specialist training for diabetes, minor illnesses, chronic obstructive pulmonary disease (COPD) and dermatology. Additional training for the practice nurse role for some staff included cervical smear training and shingles vaccinations. Newly appointed staff told us they were well supported during their induction programmes and did not undertake certain duties until they had been supervised or had undertaken the appropriate training.

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

At the time of the inspection most staff had not had an annual appraisal since 2013. The practice manager had organised dates for all staff appraisals to be commenced in April 2015. Our interviews with staff confirmed that the practice was generally supportive. Despite the absence of formal performance review nursing staff had attended training to enable them to undertake their role, for example, one nurse was undertaking a diabetic diploma supported by the practice and another had completed an asthma diploma.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required.

The practice was commissioned for an enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) to support frail patients to avoid admission to hospital. The GPs worked with a care co-ordinator based at the practice. The role of the practice co-ordinator was to work with the multi-disciplinary team (MDT) to develop and review those patients identified at risk. This included patient care plans to meet the changing needs of these patients. The relevant patients were discussed weekly with the GPs however minutes of the meetings were not kept as information for other staff. There was a process in place to follow up these patients within 48 hours of discharge from hospital.

The bi monthly Gold Standard multidisciplinary team meetings provided an opportunity to discuss the needs of other patients with end of life care needs. These meetings were attended by some community and hospice staff and minutes of the meetings were kept although we were told there were sometimes delays in updating patient records which were a resource for other healthcare professionals involved in their care.

The practice supported patients living in three nursing/care homes. A dedicated GP undertook a 'weekly ward round' in one care home to review patients care and treatment. Care plans were reviewed every three months or as required. We

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(for example, treatment is effective)

were given an example of how the GP worked with care home staff to investigate the reasons for the number of patient admissions to hospital during the night. This resulted in a review of out of hours provision.

The practice worked with the midwifery team to offer partnership care during pregnancy. In addition one GP held a weekly baby clinic for developmental checks and immunisations.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, for example, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was comprehensive information for patients about this on the practice website.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (Systmone) to coordinate, document and manage patients' care. Staff were trained on the system and additional training regarding the process of repeat prescribing was arranged. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Patient feedback demonstrated generally patients were involved in decision making and consent was sought for treatment. The GP National Patient survey (2014) indicated 73% and 58% patients felt nurses gave them adequate information and involved them in decision making (respectively) and 71% and 59% for GPs (respectively). All these results were below the CCG average. Patients we spoke with indicated staff asked for consent to treatment.

We found GPs and nurses applied the principles of the Mental Capacity Act 2005, the Children Acts 1989 and 2004

to their practice area. Nurses gave examples of how they supported patients with diminished capacity to understand and make decisions about treatment. They understood the meaning of patient consent when asked and how consent could be given. Strategies included allowing patients time, checking understanding by asking patients to repeat back their understanding of the treatment they were to receive. Nurses involved carers with the patient's permission when making decisions about treatment in the patient's best interests if a patient did not have capacity to make a decision.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing.

Overall nursing staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions) and a duty of confidentiality to children and young adults.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks in partnership with local chemists to all its patients aged 40 to 75 years.

The practice had a number of ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse and GP. The practice had a dedicated session once a week for patients over 75 years of age. These appointments enabled the GP to review plans of care, address health concerns and undertake health reviews.

The practice had strategies to enable patients to take responsibility for their own health when they were able. There was a range of health promotion information in the

Are services effective?

(for example, treatment is effective)

practice and on the website for all patient groups. Information in other languages such as Gujarati was available for patients where English was not their first language.

Young adults had access to free screening kits for chlamydia (a sexually transmitted disease) which were available for under 25's, emergency contraception and access to free confidential sexual health advice for under 19's whether registered with the practice or not.

The practice actively offered smoking cessation advice to patients. In 2014 advice was given to 1168 patients and 11 patients were recorded as having stopped smoking.

The registered manager presented data which indicated practice's performance for meeting QOF minimum standards for cervical smear screening was 100% (QOF 2015). Performance for cervical, breast and bowel cancer screening uptake was similar or significantly lower than the average for the CCG (National Cancer Intelligence Network 2013 71.3%, 78.7% and 58.1% respectively).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was equal to or above average for the CCG. There was a protocol to follow up non-attenders. Uptake for over 65's flu vaccinations (71%) had improved and was almost at the expected target of 73%. The practice had a register of 121 carers who were also offered flu vaccinations.

We saw the practice had undertaken medicines reviews of 81.5% patients with long term conditions although we noted the information was not detailed and did not identify findings from the review.

Patients who did not attend for health checks, reviews or follow up appointments were followed up by letter to arrange for another appointment if nurses or GPs were concerned about their wellbeing.

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 GP National Patient Survey (2014) and a practice survey of 97 patients (2014). The evidence from all these sources showed patients had mixed views about the practice. For example, of the 122 respondents who responded to the GP National Patient Survey (2014) 55% rated the practice as good or very good compared to the Clinical Commissioning Group average of 88%. Dissatisfaction with the practice was expressed about the difficulties of making an appointment and the length of time waiting to be seen after their appointment time. The GP National Patient Survey indicates 40% of patients rated their experience of making an appointment as very good or good compared to a CCG average of 86%.

The GP National Patient Survey (2014) identified 70% and 76% of practice respondents said the GP and nurse (respectively) was good at treating them with care and concern compared with CCG results of 85% and 82% respectively. Additionally 74% and 78% of respondents said the GP and nurses (respectively) were good at listening to them. These results were below the CCG average of 90% and 83% respectively.

Patients completed CQC comment cards to tell us what they thought about the practice. We received fifteen completed cards and spoke to eight patients. There were some mixed reviews however this was balanced overall by a number of positive comments about staff. The patients we spoke with said they felt the practice offered a satisfactory service and staff were generally compassionate, professional, supportive and caring. Overall this was confirmed by patient comment cards. Most negative comments concerned the length of time to wait for a repeat prescription. They said staff treated them with dignity and respect. We observed a number of examples of kind and caring interactions with patients.

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 / treatment

room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. In addition there was a separate room for confidential conversations.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, we noted conversations at the reception desk could be overheard by patients waiting to speak to a receptionist. We were told by patients there were plans to move the reception desk so there was more room for patients waiting to be seen. The practice switchboard was separated from reception so that telephone conversations were not easily overheard.

There was a designated person to monitor which staff looked at patient records to ensure they were not viewed unnecessarily.

Care planning and involvement in decisions about care and treatment

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 usually had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. This was supported by the practice patient survey information we reviewed which showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. However, this was not consistent with data from the GP National Patient Survey (2014) which showed 59% of practice respondents said the GP involved them in care decisions and 71% felt the GP was good at explaining treatment and results. Both these results were below the CCG average of 77% and 84% respectively.

We reviewed two patient care records which demonstrated the GPs had discussions with relatives of patients with dementia. The best interest discussions were to ensure the patient's end of life care wishes were documented.

Staff told us that translation services were available for patients who did not have English as a first language. There was a quick link to translation services on the practice website.

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room, and patient website directed patients to a range of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw there was written information available for carers to ensure they understood the various avenues of support available to them. The practice had achieved the highest award in a local project for the support they provided to carers. GP practices

participating in the project were required to demonstrate carer awareness and good practice for carer support in GP practices. They had plans to offer further carers events and continue with carers clinics in 2015.

Patients had access to LIFT psychological support sessions based at the practice. Patients were able to self-refer or could be referred by the practice. A number of staff were dementia friends with further knowledge and understanding about how to support patients with dementia and their carers. Staff told us that if families had suffered bereavement, their usual GP contacted them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice had some systems in place to maintain the level of service provided for the patient population it served.

The new practice manager had begun to implement suggestions for improvements and made changes to the way the practice delivered services in response to feedback from the patient representative group (PRG). For example, improving patient privacy and confidentiality in the reception area. We saw there was a practice plan and some actions taken to take forward other suggestions from the Patient Representative Group for example, improved prescription waiting times, increased number of telephone lines and reception staff training. We saw the practice had contacted telephone providers and were awaiting quotes to add further telephone lines. The practice manager had increased the length of time administrative staff spent processing repeat prescriptions. The practice manager told us the time taken to process prescriptions was 48 – 72 hours which had improved from seven days waiting time. However they wanted to evaluate how consistent the improvement was before informing patients and raising expectations.

The practice had an expanding patient population of which the highest proportion were of working age. In response to this the practice offered a flexible appointment system opening two evenings a week for patients not able to attend during normal working hours.

We saw from recent correspondence the practice was working in partnership with local pharmacies to undertake NHS health checks for patients aged between 40 – 75 years. Patients had the choice of attending the pharmacy or the practice. Appointments at the pharmacy were available on Saturday mornings for patients not able to attend during working hours and were booked directly with the pharmacy. There was a formal arrangement (standard operating procedure) in place for the GPs to receive the results from the pharmacy.

Patients over 75 years of age had access to appointments in a dedicated GP session once a week for review of treatment and support.

Patients had access to some specific investigations such as spirometry, 24 hour electrocardiogram (ECG) monitoring and blood testing to assess blood clotting time for patients taking blood thinning medicines therefore reducing the need for hospital appointments. Patients with long term conditions had regular health reviews.

We did not find formal systems were in place for identifying and following-up children who were at risk. However the health visitors were based at the practice and informal arrangements for reporting concerns were in place. Immunisation rates were relatively high for all standard childhood immunisations. For example, childhood immunisations at 12 months averaged over 99% compared to the Clinical Commissioning Group (CCG) average of 97.5%. Over 60% of childhood immunisations were above the CCG average the others were equal to the average.

Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. The practice offered a range of sexual health services for patients including the fitting of contraceptive coils (IUCD) and cervical smears. Young adults had access to free screening kits for chlamydia (a sexually transmitted disease) and these were available for under 25's and access to free confidential advice whether registered with the practice or not.

Tackling inequity and promoting equality

Overall the practice had recognised the needs of different groups in the planning of its services.

The practice held a register of patients with learning disabilities. The practice told us all patients with a learning disability had a person centred care plan. Longer appointments for patients with learning disabilities were arranged in recognition of the time needed to involve patients in their care and treatment. We saw 100% patients with a learning disability had a health check.

All patient services were situated on the ground floor. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Practice staff met every two months with members of the multidisciplinary team (MDT) to support patients at end of

Are services responsive to people's needs?

(for example, to feedback?)

life. A nurse co-ordinator employed by the CCG worked part-time at the practice to work with the GPs and MDT to develop care plans and monitor patient wellbeing to avoid unplanned admissions to hospital. GPs supported patients living in care homes to have access to practice services. Support included a weekly ward round in one care home for patients with dementia.

The practice had access to online and telephone translation services for patients where English was not their first language. There was specific information in other languages for patients with diabetes to enable them to understand their care and treatment.

Access to the service

The practice opened 8.30 am – 6.15 pm Monday, Tuesday and Friday and late opening until 7.30pm on Wednesdays and Thursdays. However, the practice systems did not facilitate easy access to some services. Patients told us they were usually able to access on the day consultations with either the nurse or doctor. All on the day urgent appointments were triaged by the practice nurse who identified those patients requiring to see a GP on the day or within the following 48 hours. The triage nurses also offered face to face or telephone consultations for patients with minor illnesses. Minor illnesses included coughs and colds. They did not see patients aged two years and under. These patients would always see a GP. Likewise patients presenting with abdominal pain were referred to a GP. We were told if the triage nurses had concerns or required further advice during the consultation the patient would be seen by a GP.

Patient feedback identified there were challenges in getting a routine appointment, waiting times, getting through to the practice by telephone and the length of time taken for the issuing of repeat prescriptions. Patients requesting to see a GP for a routine appointment told us they frequently waited for two to three weeks and up to six weeks for one particular GP of choice. This was confirmed by data from the practice electronic system. Some patients indicated it was difficult to get through to the practice by telephone to make an urgent appointment particularly when the practice first opened in the mornings. This was supported by information from the GP National Patient Survey 2013/14 where only 46% of respondents found it easy to get

through by telephone. We spoke with three patients who told us coming into the practice was the only way to book a routine appointment due to the difficulties of telephone access.

We looked at 12 examples to demonstrate the length of time patients waited after their appointment time. 50% of the examples we looked at demonstrated patients waited longer than 15 minutes. The longest wait was 70 minutes with an average wait of 30 minutes. On the day of the inspection there were 11 GP appointments available for patients requiring a same day appointment. Patients told us they valued the nurse triage appointment system which enabled them to have a same day consultation. Patients also told us they appreciated they were able to book appointments up to four weeks in advance which helped with planning work commitments.

The waiting time for a patient's repeat prescription issue had been up to seven days. Patients were made aware of this via the practice website and notices in the practice. The practice manager had reviewed the system to manage repeat prescriptions and dedicated staff were enabled to spend more time dealing with requests. Initial data we looked at confirmed most repeat prescriptions were being issued within two to three days of receipt.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the practice leaflet and website.

Appointments were available outside of school hours for children and young people. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three care homes including a 'weekly ward round' at one of the homes.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

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

We saw that information was available to help patients understand the complaints system. Most patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with on the day of the inspection had ever needed to make a complaint about the practice.

The practice reviewed complaints regularly to detect themes or trends. 35 complaints 13 of which were verbal complaints were reported in 2014/15. We looked at the complaints and five concerned appointments. The remaining complaints had no recurring themes. Lessons learned from individual complaints had been identified and acted on. We saw the practice manager had responded satisfactorily to comments made on the NHS website.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice had a clear understanding of the strengths and challenges to the practice and the patients it supported. The newly appointed practice manager had worked with the GPs to develop a comprehensive action plan to demonstrate how identified risks and suggestions made by patients and staff were to be managed and achieved. They gave examples of how and where short and medium term improvements could be made. The required improvements reflected the challenges the practice had encountered during the previous two years as a result of staffing issues and low staff morale. We saw there had already been some improvements made, for example, an increase in administration time for the processing repeat prescriptions which had resulted in improvements of waiting times. We saw the Quality and Outcomes framework results (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually) had improved.

Overall we were told there was a general feeling of teamwork and support for the successful implementation of the plan. Staff and patients told us they had noticed positive changes in the practice for example, the first patient meeting for some time and schedules for staff appraisal. Staff we spoke with were aware of the need for change and understood their role in improving the service provided. The practice statement of purpose emphasised the delivery of high quality care and the promotion of good outcomes and continuous quality monitoring. We observed staff were conscientious, caring and respectful and were focussed on delivering the changes required.

At the time of the inspection there was no clear sense of a long term strategy or vision for the practice. The GPs and practice manager explained the focus had previously been to manage the day to day issues of practice management and the immediate priorities were to develop systems to protect patient safety and improve and maintain the quality of the service.

Governance arrangements

The practice leadership had a clear understanding of the risks and challenges of improving and maintaining the quality of the service. There was a leadership structure which had named members of staff in lead roles. For example, there was a nurse with lead responsibilities for infection control and two GPs had lead responsibilities for safeguarding and the appointment of a practice manager at the beginning of 2015 following staff absence of a year.

The practice had policies and procedures in place to govern activity and these were available to staff in each department. We looked at a range of these policies and procedures and found some of them needed to be reviewed. We found there were duplicates or they had been written on in order to update or dates were not clear. Examples included diabetes and glucose tolerance testing (blood test for diabetics) hypertension (high blood pressure). Some policies had been updated in 2013 such as safeguarding, recruitment and consent. We found these to be comprehensive and a useful resource for staff. There was no policy review schedule to serve as a formal reminder for staff to update or review.

The practice held regular team meetings for nurses, GPs, reception staff. Those team meeting which were minuted included governance issues such as performance, quality and risks. Minutes from the weekly GP meetings were not minuted with the exception of significant events. These meetings included information from the care co-ordinator regarding updates on at risk patients. We were told recording of these minutes was to start at the next available meeting. The significant event and complaints records were consistently completed at the weekly practice meeting. These were available as a resource for GPs however, there was not a dedicated meeting for other staff to attend particularly if they were involved in the incident or complaint. Staff told us they generally had feedback from these meetings via their team leader who attended a team leader meeting every two weeks.

The GPs met with the multidisciplinary team every two months to discuss patients with end of life needs. Regular meetings with health and care professionals involved in the protection of children, families and adults at risk were not regularly scheduled.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice (March 2015) showed there had been significant

Are services well-led?

Requires improvement 

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

improvements in the measurement and recording since 2013/14 when it was not performing in line with local and national standards. Their overall achievement stood at 86% (March 2015) compared to 79.4% in 2013/14.

There were three audits (2014) available for us to see on the day of the inspection. One audit had completed a full audit cycle to demonstrate the effectiveness of the changes made. Audit regarding other processes and systems such as referrals to secondary care and minor surgery undertaken were not implemented.

The practice had a schedule to assess and update practice risk assessments. The schedule included the frequency and date of assessment. We saw these had been completed on time.

Leadership, openness and transparency

Staff we spoke with were clear about their own roles and responsibilities. Staff told us they enjoyed working at the practice, were well supported by their teams and knew who to go to in the practice with any concerns. We saw examples of how staff development needs had been addressed for example, one member of reception staff had phlebotomy training to prepare them for their role. Other staff had attended professional development courses to prepare them for their role. However, not all staff had a documented annual appraisal and personal development plan to support their learning and development needs. We saw examples of the nurses' induction and back to work programme which was thorough. Staff told us they were mentored and supported by nursing team members until they felt confident to undertake specific procedures or until they had the relevant training.

They said overall they were well informed of practice issues via team leaders and team meeting records although some staff indicated they would have liked greater inclusion in the range of practice meetings that took place. Practice business plans demonstrated the practice leadership team were aware of this and had plans to address the issue.

We saw evidence of changes to practice resulting from learning from incidents and significant events. For example, a review of all patients on high risk medicines to monitor when blood tests were performed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies,

for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. Overall, these were well organised, up to date and reflected current HR procedures.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through patient surveys, complaints and the patient representation group (PRG). The results and actions agreed from these surveys were available on the practice website. The practice had a small, active virtual PRG group who until recently had not met regularly with the practice. Patients told us they had a productive first meeting with the practice and another had been planned. We looked at the results of the PRG annual patient surveys (2014) and questions raised by patients to the group. The practice had started to respond to a range of comments including improving the repeat prescription procedure to ensure repeat prescriptions were managed in a timely manner. A comprehensive action plan with timescales was in place which addressed other concerns of patients and staff.

Staff told us they were able to give feedback and discussed any concerns or issues with colleagues and management. Overall staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available for all staff to read as guidance.

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews, records and policy reviews indicated management did not consistently lead through learning. There was inconsistent recording of meeting minutes which would have acted as a resource for staff unable to attend the meetings. Staff involved in significant events, complaints and incidents did not participate in meetings where action and learning took place.

Nursing staff told us they were able to remain updated with mandatory training and continuing professional development requirements for example, immunisations and basic life support. However, incomplete training records and other corroborative evidence was not consistently available on the day to confirm this. We were told staff told had not had an appraisal or performance

Are services well-led?

Requires improvement 

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

review since 2013. Dates for reviews in 2015 had been booked. We saw and staff confirmed that new staff were supported via an induction programme with specific support to orientate and train them for their role.

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	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>We found the registered person had not protected people against the risk of abuse. This was in breach of regulation 11(1) (a) (b) Health & Social Care Act 2008. (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.</p> <p>The registered person failed to make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse, prevent it before it occurs and responding appropriately to any allegation of identified abuse.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>We found the provider was in breach of regulation 20(1)(a)(b)(11)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Patients were not protected against the risks of unsafe or inappropriate care because accurate records were not maintained in relation to their care and treatment. In relation to persons employed for the purposes of carrying on the regulated activity.</p> <p>Other records as are appropriate in relation to -</p> <p>(1) persons employed for the purposes of carrying on the regulated activity.</p>

This section is primarily information for the provider

Compliance actions

Regulated activity

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18(2) HSCA (RA) Regulations 2014 Staffing

We found the provider was in breach of regulation 23 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate records were not kept of staff training. The registered person could not demonstrate staff had undertaken all the training necessary to fulfil their role.