Green Meadows Partnership

Quality Report

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Date of inspection visit: 17 June 2015
Date of publication: 13/08/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Green Meadows Partnership on 17 June 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe services and being well led. The population groups for older people, people with long term conditions, families children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health were rated as inadequate based on the overall rating of the practice. Improvements were also required for providing responsive and effective services. The practice was rated as good for providing a caring service.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment and actions identified to address concerns with infection control practice had not been taken.
- The practice did not have robust governance arrangements to effectively manage risks to protect patients from harm and improve the quality of services provided.
- The practice had no clear leadership structure, insufficient leadership capacity and in effective governance arrangements.
- Patient outcomes are average for the locality. Patients' needs are assessed and audits had taken place.
- Patients said that they are treated with compassion, respect and dignity and are involved in decisions about their care and treatment.

The areas where the provider must make improvements are:

Summary of findings

- Review recruitment arrangements to include all necessary employment checks are undertaken for all staff and appropriate records kept.
- Develop a structured induction training programme for all new staff.
- Support all staff at the practice to provide individual feedback such as appraisal.
- Implement the systems to assess and manage the risks of health related infections. For example, ensuring patients, staff and visitors are protected from the risk of water borne infection by means of completing a legionella risk assessment.
- Ensure there are formal governance arrangements in place and staff are aware how these operate to ensure the delivery of safe and effective services.
- Ensure all staff have access to appropriate policies, procedures and guidance to carry out their role, such as information about whistleblowing .and safeguarding.
- Implement effective systems to identify, assess, and manage risks relating to the health, welfare, and safety of patients, and others who may be at risk.
- Ensure there are mechanisms in place to seek feedback from staff and verbal feedback from patients is recorded. To ensure the practice is responsive to patient feedback and staff views on improving the service.
- Ensure there are formal arrangements in place and staff are aware how these operate to ensure the security of prescriptions in accordance with national guidance.

In addition the provider should:

- Ensure all members of staff are aware of how to locate the practice's safeguarding policies and the telephone numbers and names of people to ring should they have urgent safeguarding concerns.

On the basis of the ratings given to this practice at this inspection and the concerns identified at the two previous inspections in February 2014 and September 2014 the provider has been placed into special measures. This will be for a period of six months when we will inspect the provider again. Special measures is designed to ensure a timely and coordinated response to practices found to be providing inadequate care.

Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid having its registration cancelled.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Patients were at risk of harm because the practice did not have effective systems in place to ensure that cleanliness was maintained and that the risk of infection was assessed and controlled. The practice did not have a robust health and safety policy in place and there were no records of any checks of the building or the environment.

Not all staff had appropriate checks undertaken before they commenced employment.

We also found that blank prescription forms were not handled in accordance with national guidance to ensure they were tracked through the practice.

Most staff knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff understood their responsibilities to raise concerns, and to report incidents and near misses.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Some staff we spoke with felt they were not supported to undertake their roles. Some training had taken place but there was limited evidence to confirm this. Staff had not received regular training updates. For example in infection control and the Mental Capacity Act. Some staff had not received an appraisal for a number of years.

Our findings at inspection showed that systems were in place to ensure that GPs and nurses were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving outcomes for patients. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff worked with multidisciplinary teams.

The practice used innovative and proactive methods to improve patient outcomes with a comprehensive immunisation programme.

Summary of findings

The practice used information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We looked at the QOF data for this practice which showed at 93.4%, the practice was performing below the CCG average of 96.6% and below the national average of 94.2%.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. This was reflected in data from the national patient survey as practice patients rated the practice higher than local and national averages when asked about being treated treating with care and concern.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Views of external stakeholders were positive and aligned with our findings.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Patient feedback had influenced the way the practice delivered appointments. However, further feedback from patients showed that access to a named GP and continuity of care was not always available, although urgent appointments were usually available the same day.

Patients could get information about how to complain in a format they could understand. However, there was no evidence that verbal and face to face complaints had been recorded or shared with staff.

The practice website had not been updated since December 2014. It contained out of date information, for example in regard to practice opening times, and could be misleading for patients seeking information about the practice.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

It did not have a clear vision and strategy, although all staff displayed values consistent with an emphasis on caring for patients.

The leadership of the practice had not created an environment of continuous learning and improvement. There was no clear leadership structure and several staff commented they were not

Summary of findings

supported by managers and the GPs. Some staff told us there was no team culture; they felt undervalued and expressed a low level of job satisfaction. Staff told us they had not received regular performance reviews, appraisals and did not have clear objectives.

There were systems in place to monitor and improve quality and identify risk but they were not effective.

The practice had a number of policies and procedures to govern activity and held regular governance meetings.

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

Inadequate

The provider was rated as inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over the age of 75 had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, for those identified as at risk of hospital admission and end of life care. The practice provided daily home visits to older people who were unable to get to the surgery and weekly visits to residents in local care homes.

The practice was aware of the gold standards framework for end of life care and knew how many patients they had who were receiving palliative care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice team worked in partnership with other professionals including health visitors, district nurses and specialist services such as the diabetes retinal screening service and mental health teams.

Doctors had lead roles in chronic disease management. For example, some doctors and nurses had specialist training and interests in diabetes. We saw that a register of patients with diabetes was kept and that individuals with diabetes received regular follow up.

Data for a number of long term conditions showed outcomes for patients were good. For example, the practice had achieved better than the national average for most aspects of care of patients with diabetes.

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness. Last year's performance for all influenza immunisations was

Summary of findings

significantly higher than the CCG average where comparative data was available. For example, flu vaccination for patients in a defined high risk group was 62.2%. This was above CCG and National averages.

Families, children and young people

Inadequate

The provider was rated as inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Childhood immunisation rates for the vaccinations given in 2014/15 were very good for all standard childhood immunisations. Immunisation rates for under two year olds ranged from 94.7% to 95.8% and five year olds from 93.7% to 100%. These were well above the CCG and national averages.

Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice would refer pregnant women to a midwife and share their care during the pregnancy. There were clear arrangements for multidisciplinary working and we saw good examples of joint working with district nurses and health visitors.

There were some systems in place to ensure the safety and welfare of people using the service. There were processes in place to identify and follow up children who were at risk, for example children on the safeguarding register. However, not all staff were aware of the practice's escalation process in raising a safeguarding concern.

Staff were aware of the procedures for assessing capacity and consent for children and young people.

Appointments were available outside of school hours and the practice displayed information to promote the welfare of children and young people in the waiting room.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of working-age people (including those recently retired and students).

The practice website had not been updated since December 2014 and gave patients limited information regarding practice services. At the time of inspection the practice was trailing online booking of

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appointments via the website and could order repeat prescriptions. The practice had plans to update the website and include a range of health promotion information. There was no timescale set for this work.

The practice made the majority of hospital referrals via e-referrals formally known as "Choose and Book", which gave patients flexibility when booking their hospital appointments.

Extended hours appointments were available four weekday mornings a week from 7.00am to 8.00am.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice was rated as inadequate for the care of people whose circumstances may make them vulnerable.

The practice had an appointed lead in safeguarding vulnerable adults and children.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients had access various support groups and voluntary organisations. Not all staff knew how to recognise signs of abuse in vulnerable adults. Some staff were not aware of how to contact relevant agencies in normal working hours and out of hours.

Staff understood the process of assessing mental capacity and seeking consent.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice regularly worked with multi-disciplinary teams in the care of patients experiencing poor mental health, including those with dementia.

70.7% of patients diagnosed with dementia had received a face-to-face review in the preceding 12 months. The practice had recognised this was lower than both the CCG average of 81.3% and the National average 77.9%. They had developed an action plan to increase the number of face-to-face reviews completed and increase advance care planning for patients with dementia. .

Longer appointments were available for those experiencing poor mental health.

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What people who use the service say

We spoke with 11 patients visiting the practice and we received six comment cards from patients who visited the practice in the two weeks prior to inspection. We spoke with patients from various groups including mothers and fathers with young children, working age people, older people and people with long term conditions.

We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the last two Care Quality Commission inspection reports about the practice.

We reviewed the results from the latest National GP Patient Survey (published in January 2015) and found the responses confirmed the experiences we heard from patients. There were 273 surveys sent out, 129 returned giving a completion rate of 47%. The survey found the proportion of patients who would recommend their GP surgery was 81% which was 8% above the average for Bracknell and Ascot Clinical Commissioning Group (CCG). 98% had confidence and trust in the last GP they saw or spoke with which was above the CCG average of 94% and 85% of respondents say their experience of the service was good or very good.

The GP Patient Survey found 50% of respondents find it easy to get through to the surgery on the phone, which was significantly lower than the CCG average. The practice had implemented four changes to the appointment system in May 2015, following implementation of these changes patients told us appointment accessibility had improved.

We also considered evidence from the feedback we received on the day from six completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. They told us that long term health conditions were well monitored and supported. The patients we spoke with in the day of inspection confirmed this. They also explained how they felt listened to and understood their treatment and care.

Areas for improvement

Action the service MUST take to improve

- Review recruitment arrangements to include all necessary employment checks are undertaken for all staff and appropriate records kept.
- Develop a structured induction training programme for all new staff.
- Support all staff at the practice to provide individual feedback such as appraisal.
- Implement the systems to assess and manage the risks of health related infections. For example, ensuring patients, staff and visitors are protected from the risk of water borne infection by means of completing a legionella risk assessment.
- Ensure there are formal governance arrangements in place and staff are aware how these operate to ensure the delivery of safe and effective services.
- Ensure all staff have access to appropriate policies, procedures and guidance to carry out their role, such as information about whistleblowing and safeguarding.
- Implement effective systems to identify, assess, and manage risks relating to the health, welfare, and safety of patients, and others who may be at risk.
- Ensure there are mechanisms in place to seek feedback from staff and verbal feedback from patients is recorded. To ensure the practice is responsive to patient feedback and staff views on improving the service.
- Ensure there are formal arrangements in place and staff are aware how these operate to ensure the security of all prescriptions in accordance with national guidance.

Summary of findings

Action the service SHOULD take to improve

- Ensure all members of staff are aware of how to locate the practice's safeguarding policies and the telephone numbers and names of people to ring should they have urgent safeguarding concerns.

Green Meadows Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**. The team included three specialist advisors (a GP, a Nurse and a Practice Manager) and an Expert by Experience.

Experts by experience are members of the team who have received care and experienced treatment from similar services. They are granted the same authority to enter registered persons' premises as the CQC inspectors. The team was accompanied by a CQC Inspection Manager in an observer role.

Background to Green Meadows Partnership

Green Meadows Partnership has been a family practice since the 1930s and is situated north of Ascot racecourse, in Berkshire. Green Meadows Partnership is one of 15 practices within Bracknell and Ascot CCG. There are 10,089 registered patients. The practice comprises of two buildings, one of which is a purpose built surgery and the other a converted suburban house known as Knightswood.

The surgery comprises of a large reception area housing two receptionists, seven GP consultation rooms, an examination/ECG room and two separate nurse rooms around the perimeter of the building. Two administration areas are within the centre of the surgery, one directly behind reception and the other being within the centre of the building.

Knightswood, the converted house, is separate from the surgery but connected by a covered walkway. It comprises of two consultation rooms and one minor surgery operating room, all of which are located on the ground floor.

There are eight GPs (three male and five female) at the practice comprising of five partners and three salaried GPs. The all-female nursing team consists of five practice nurses with a mix of skills and experience. A practice manager, two assistant practice managers and a team of fifteen administrative staff undertake the day to day management and running of the practice. The practice has a General Medical Services (GMS) contract.

The practice is a training practice for GP Registrars. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

The practice is open between 08:00 and 18:30 Monday to Friday. Extended hours are offered from 07:00 to 08:00 Tuesday to Friday mornings.

The practice population has a proportion of patients in three local care homes (119 registered patients) and one local independent boarding school for girls (98 registered patients).With 1.17% of patients in a residential or nursing home (higher than the national average), the practice holds twice weekly clinics at three local care homes.

The practice opted out of providing the out-of-hours service. This service is provided by accessed via the out-of-hours NHS 111 service. Advice on how to access the out-of-hours service is clearly displayed on the practice website and over the telephone when the surgery is closed.

The practice was inspected in February 2014 and we identified breaches in the regulations relating to Safeguarding, Cleanliness and infection control and Assessing and monitoring the quality of service provision.

Detailed findings

We undertook and follow up inspection in September 2014 to review the previous breaches in regulations. We found the provider had not acted upon the information provided to them in February 2014 and further breaches were found in relation to Cleanliness and infection control and Assessing and monitoring the quality of service provision.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

This provider had been inspected twice before and on both previous inspections found that the practice was not meeting all the essential standards of quality and safety. Therefore, the current inspection also took place in order to follow up on the areas highlighted in the last inspections.

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?
- Is it well-led?

We also looked at how well services were 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 visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from Bracknell and Ascot Clinical Commissioning Group (CCG), local Healthwatch, NHS England and Public Health England.

We carried out an announced inspection on 17 June 2015.

During the inspection we spoke with four GPs, two nurses, members of the management team, two members of the patient participation group, and members of the administration and reception team.

We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

We obtained patient feedback from speaking with patients, CQC patient comment cards, the practice's surveys and the GP national survey.

We observed interaction between staff and patients in the waiting room.

We asked three local care homes and the school which the practice served about the service they received from the practice. They told us the practice was very responsive to patients needs and treated them with dignity and respect.

Inadequate

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, when one of the GPs had not initially recognised symptoms of a long term degenerative disease they sought guidance from an expert organisation involved with this particular disease. The learning was shared with other GPs and we saw that an early diagnosis had been made for a patient with the same disease at a later date.

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 and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last year and saw the system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. 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.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of action taken as a result and that the learning had been shared. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again in line with the practice policy.

National patient safety alerts were disseminated to the practice manager or the GPs. Minutes of staff meetings showed alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Staff we spoke with were able to give examples of recent alerts that were relevant to their roles and care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. However, some staff we spoke with were unsure of how to locate the practice's safeguarding policies and procedures, the telephone numbers to ring should they have urgent safeguarding concerns or how to recognise the different signs of abuse. Similarly, not all staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles.

There was a chaperone policy which was visible in the waiting room and on the doors of consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). One of the GP partners told us that only clinical staff carried out chaperone duties and they had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures and staff were aware of the action to take if the fridge temperature was not maintained. We noted that the procedure had recently been followed in

Are services safe?

April 2015 when a medicine fridge had been inadvertently turned off. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. The cold chain policy which the practice staff followed included the safe disposal of expired medicines, in line with waste regulations, Health Protection Agency guidance and Vaccination Immunisation direction from Public Health England.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for the use in printers and those for hand written prescriptions were not handled in accordance with national guidance. They were not tracked through the practice or kept securely at all times. On the day of inspection we found hand written prescriptions stored in an unlocked drawer in an unlocked room.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated and reviewed in April 2015.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However, we observed that not all areas of the practice were clean and tidy. For example, not all of the clinical areas were clean and dust free; in the minor operations room we found thick dust on the equipment trolley, dirty sinks and one of the fridges in the room was also dirty. Also in one of the treatment rooms we found dirty and stained walls and high level dust on shelves and blinds. Similar instances of inappropriate standards of cleanliness had been found during the inspections in February 2014 and September 2014.

We saw that there were cleaning schedules in place and cleaning records were kept. However, these were not specific to the practice. The cleaning schedule for the minor operations room identified that carpets were vacuumed daily, however there were no carpets in the minor operations room. The monitoring of cleaning within the practice was not effective and had not identified the concerns we found on the day of inspection.

One of the GPs was the lead for infection control and supported by the practice manager. An infection control audit had been completed in December 2014. We reviewed records which identified that not all actions from the audit had been completed. For example, undertaking a risk assessment or testing to minimise the risk and spread of legionella. The practice had purchased legionella testing kits for the practice to test the water and send to a specialist company for analysis. However, the testing kits were not in use. The practice had not undertaken a risk assessment and did not have an effective process or policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings and can be potentially fatal).

On the day of inspection records to confirm staff's immunity to Hepatitis B (a blood borne virus) were not available. However, these were presented immediately after the inspection which provided the Hepatitis B status of all of their staff.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. The practice had a policy explaining what sharps were and a brief risk assessment for dealing with needle stick injuries. 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 most of the treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. All portable electrical equipment was routinely tested and displayed stickers indicating the last tests had been completed in November and December 2014. We saw scheduling of testing was in place.

They told us that all other equipment was tested and maintained regularly. The practice provided equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment completed in July 2014. We saw a planned schedule for further calibration in July 2015. The practice provided correspondence of the calibration testing but this was

found not to relate to Green Meadows Partnership and was for a practice in a different county. Following the inspection the practice contacted the company which provided the calibration; they have apologised for the error and provided a paper copy of the equipment calibration.

Staffing and recruitment

We looked at six staff records and found that appropriate recruitment checks had not been undertaken prior to employment. For example, four staff files did not contain proof of identification; several had no contract, the nurse file had no PIN number and the GP file had no GMC registration information. There were no other records to show that the practice undertook regular checks to confirm the on-going professional registration of the GPs or nurses. Other staff files had no records of references, qualifications, and registration with the appropriate professional body was not included. The practice was not following their own recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

On the day of inspection the practice could not supply evidence that Disclosure and Barring Service checks had been completed for all staff. However, the practice supplied appropriate evidence of completion of these checks following the inspection.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor the risks to patients, staff and visitors to the practice. The practice had arrangements with external professionals who completed extensive checks of the building and environment to identify and mitigate any risks to patients.

There was a health and safety policy in place however it was not clear this was being followed in practice. We spoke with the practice manager about health and safety risk assessments and processes. It was clear from these discussions that the practice manager did not have the relevant skills and knowledge to ensure effective monitoring of health and safety in the practice.

We saw evidence that fire extinguishers had been checked in September 2014. Staff we spoke with told us they had not received fire safety training nor practised fire drills.

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. We spoke with staff who told us they had received annual training and it was clear they knew what to do in the event of an emergency such as sudden illness. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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

A comprehensive business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated 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. For example, contact details and contingency plans for short and long term loss of the telephony system and a section which details actions arising from pandemic and epidemic situations. The plan was last reviewed in 2015.

A copy of the business continuity plan was kept off the premises in hard copy by the practice manager and at least one of the partners, who also held a hard copy on the premises located on the kitchen staff notice board and in the fire folder in reception.

Requires improvement

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 local commissioners.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

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

We noted a good skill mix among the doctors with a number having additional qualifications and special interests. For example, one GP had a post-graduate certificate in diabetes care; another GP was an approved Out of Hours Clinical Supervisor and one of the practices salaried GPs was the immunisation lead for East Berkshire.

The GPs told us they led in specialist clinical areas such as diabetes, cardiology, children's health and obstetrics, the practice nurses supported this work, which allowed the practice to focus on specific conditions. One of GPs performed minor surgery at the practice and was also a GP trainer. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

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

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

Management, monitoring and improving outcomes for people

Information about patient care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us 12 clinical audits that had been undertaken in the last year. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF).

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw several clinical audits including an audit of minor operative procedures and injections between April 2014 and January 2015.

An example of a completed clinical audit was a comprehensive audit on minor surgical procedures (89 procedures April 2014-January 2015) ensuring these were completed in line with their registration, local (East Berkshire) and National (National Institute for Health and Care Excellence) guidance.

We also saw an example of a current clinical audit on pneumococcal vaccine in patients with coeliac disease nearing completion. In January 2015, an audit was undertaken to identify pneumococcal vaccine in Green Meadow surgery patients with a diagnosis of coeliac

disease. Patients with coeliac disease are may be vulnerable to serious bacterial infection. The practice completed a comprehensive search on these patients to identify those who have had been given the pneumococcal vaccine.

Twenty one out of 31 current patients with coeliac disease had not been immunised against pneumococcus. This audit was presented and discussed in detail at a clinical meeting in February 2015. After discussion it was decided to offer vaccination to the group of 21 patients. The practice planned to re-audit later in the year. The audits we reviewed were two cycle audits which had been repeated to monitor improvements.

The practice used information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We looked at the QOF data for this practice which showed at 93.4%, the practice was performing below the CCG average of 96.6% and below the national average of 94.2%. Specific examples to demonstrate good QOF performance include:

- The practice's performance for the cervical screening programme was 90.9%, which was above the national average of 81.9%.
- The practice's performance for influenza vaccination for patients in a defined clinical risk group was 62.1%, which is higher than the national performance of 52.3%.

Whilst examples of below national average QOF performance include:

- 73.4% of patients diagnosed with dementia whose case has been reviewed in a face-to-face review in the preceding 12 months. This is below the national average of 83.8%.
- 77% of patients with hypertension who have had a blood pressure reading measured in the preceding 9 months. This is below the national average of 83.1%.

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

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal meetings as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice described and presented evidence of complimentary feedback from the family of a palliative care patient.

The practice's prescribing rates were similar to national figures with the exception of non-steroidal anti-inflammatory medicines. The practice prescribed 75.2% which is slightly higher than the national average of 71.3%.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also kept a register of patients identified as being at high risk of admission to hospital. Annual reviews were also undertaken for people with long term conditions such as Diabetes, COPD, Asthma and Heart failure.

We spoke with the local CCG before the inspection and they confirmed that the practice did not always participate or fully engage in local CCG benchmarking. This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Effective staffing

Practice staffing included GPs, practice nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended safeguarding vulnerable adults training and basic life support. However, we were unable to evidence that staff had received other mandatory training such as information governance, infection control and health and safety which were relevant to staff's role.

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).

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice did not have an induction programme that prepared staff for their new role. Newly employed staff had not received comprehensive and structured induction training. The new practice manager had received a one day induction with very limited support and training since the commencement of their employment in October 2014. We spoke with the practice manager and they expressed their concerns about the lack of training and support from the GPs and practice. They explained how, following a recent conversation with the GPs, the practice had made arrangements for a retired and experienced practice manager to support and mentor them.

Staff did not receive a regular appraisal of their performance to identify training, learning and development needs. Our discussions with staff who had worked at the practice for more than 12 months confirmed not all staff had an annual appraisal in the preceding year. Other staff reported not having an effective appraisal for years.

The practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. There were currently no trainees working at the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. We saw that all staff had signed a confidentially statement which outlines the responsibilities to comply with the requirements of Data Protection Act 1998.

Emergency hospital admission rates for the practice were relatively low at 10.1% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a regular audit of follow-ups to the process was effective.

There was evidence that the practice worked closely with other organisations and health care professionals. We saw that the GPs had regular multidisciplinary meetings with representatives from the community nursing team, mental health services and adult social care to discuss the needs of patients with mental health problems.

The practice told us they had established a good working relationship with three local residential care homes. The three care homes provide a combined patient list of 119 registered patients, the practice operated a twice weekly GP led clinic at the homes, where residents could be seen and assessed as appropriate. We spoke with managers from the each of the care homes who told us that the practice provided a good service which was effective in meeting resident's needs.

The practice also worked with a local independent boarding and day school. Comments from the school were complimentary about the care provided by staff, their friendliness and behaviour. They said they were satisfied with the care and they felt listened to and were treated with dignity and respect.

The practice also has share care agreements with the Berkshire Memory Clinic. If a patient at the practice was diagnosed with dementia, they could be offered medication which was reviewed both by the named GP and the memory clinic staff at timely intervals. The practice also offered other interventions such as post-diagnostic counselling and therapy as well as advice on planning for the future.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care. Staff we spoke with knew how to use the system and said that it worked well. The EMIS software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice had not undertaken any specific audits to assess the completeness of these records in order to identify and address any potential shortcomings.

Systems were in place for making referrals through the NHS e-Referral Service, which replaced Choose and Book

system in June 2015. This system enables patients to choose which hospital they wished to be seen in and book their own outpatient appointments in discussion with their chosen hospital.

The practice had signed up to the electronic Summary Care Record (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 information on the practice website which gave further explanation and a statement of intent with reference to electronic patient records including information to opt out of Summary Care Record.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw that hard copies of letters and other information were scanned onto the system on the day it was received and forwarded to the GP for action. Staff told us that they were up to date with scanning, coding and follow up of electronic patient information.

Consent to care and treatment

We found administration and reception staff had some awareness of the principles of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. However, they had not received training to ensure they fully understood their duties in fulfilling it. All the GPs and practice nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

We were shown the Mental Capacity Act Tool Kit which was stored on the practice shared drive. This tool kit provided a guide to the act including the legal framework and local contact numbers.

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

During our discussions staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The GPs and practice nurses demonstrated a clear understanding of the Gillick competency test. The lead GP demonstrated a comprehensive understanding of Gillick competency and Fraser guidelines. (These were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice followed guidance and local initiatives set by the CCG to meet the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. One GP showed us how patients were followed up as appropriate if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had many ways of identifying patients who needed support, and it was pro-active in offering additional help. A nurse we spoke with told us there were a number of services available for health promotion and prevention. These included clinics for the management of diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD) and cervical screening. The practice had also identified the smoking status of 95.9% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

There was a range of patient literature on health promotion and prevention including local smoking cessation information available for patients in the waiting area. The practice website provided patients with limited health advice and information about healthy lifestyles.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice's performance for the cervical screening programme was 90.9%, which was above the national average of 81.9%.

The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening, this was reflected in data from Public Health England:

- 63% of patients at the practice (aged between 60-69) have been screened for bowel cancer in the last 30 months; this was higher than the CCG average of 58% and higher than the national average which was also 58%.
- 83% of female patients at the practice (aged between 50-70) have been screened for breast cancer in the last 30 months; this was higher than the CCG average which was 77% and higher than the national average which was 73%.

Health promotion and prevention advice as offered to help patients with mental health problems. For example, the 2013/14 QOF data showed 70.7% of patients diagnosed with dementia had received a face-to-face review in the preceding 12 months. The practice had recognised this was lower than both the CCG average of 81.3% and the National average 77.9%. They had developed an action plan to increase the number of face-to-face reviews completed.

One GP at the practice was the immunisation lead for the CCG. The practice had comprehensive systems in place for monitoring immunisations in line with national guidance. Records showed the GP proactively sought and promoted improvement in immunisation management and this was evident in the immunisation data as the practice was above both local and national averages for influenza and childhood immunisations. Childhood immunisation rates for the vaccinations given in 2014/15 to under two year olds ranged from 94.7% to 95.8% and five year olds from 93.7% to 100%. These were well above the CCG and national averages.

Last year's performance for all influenza immunisations was significantly higher than the CCG average where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 73.6%, and at risk groups 62.2%. These were above CCG and National averages.
- Flu vaccination rates for patients with diabetes (on the register) was 98.1% which was above the National average of 93.4%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey results (129 respondents), NHS Choices website (39 reviews) and comment cards completed by patients as part of the family and friends test. The evidence from all these sources showed patients were satisfied with how they were treated, and this was with compassion, dignity and respect.

Data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. Ninety eight percent of patients said they had confidence and trust in the last GP they saw which when compared is higher than the CCG average of 94% and national average of 95%. Ninety eight percent of patients said the GP gave them enough time which when compared is higher than the CCG average of 92% and national average of 92%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received six completed cards all but one were very positive about the service experienced. Patients said the practice offered an excellent service and staff were sincere, welcoming and caring. They said staff treated them with respect and were genuinely interested in their wellbeing. One comment card we received was less positive and made reference to the length of appointments at the practice.

This feedback was confirmed by all eleven patients we spoke with on the day our inspection. This included two members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Staff and patients told us 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

None of the feedback received raised any concerns in relation to discriminatory behaviour or where patients' privacy and dignity was not being respected. Staff we spoke with were not aware of an equality and diversity policy and staff training records seen did not show that staff had received any training in this area. However, 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 GP and practice manager.

Care planning and involvement in decisions about care and treatment

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

- 86.7% said the last GP they saw was good at explaining tests and treatments which was higher when comparing to the CCG average of 78.9% and national average of 82%.
- 95% said the last nurse they saw was good at explaining tests and treatments which was higher when compared to the CCG average of 88% and national average of 90%.
- 99% said they have confidence and trust in the last nurse they saw which was higher when compared to the CCG and national average.

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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

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

- 83% said the last GP they spoke with was good at treating them with care and concern which was slightly above the CCG average of 81% and but below the national average of 85%.
- 94% said the last nurse they spoke with was good at treating them with care and concern which was above both the CCG and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. These highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the TV screen told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to patient's needs and had systems in place to maintain the level of service provided. The practice held information about those who needed extra care and resources such as those who were housebound, patients with dementia and other vulnerable patients. This information was utilised in the care and services being offered to patients with long term needs. For example patients who were housebound were provided with regular contact and given priority when contacting the practice to organise appointments and treatments. We were able to see records of contacts and appointment scheduling for housebound patients which corroborated what we had been told.

The practice was engaged with their Patient Participation Group (PPG) and feedback from patients was obtained proactively. There were regular meetings of the PPG attended by the practice manager. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys. The practice responded to comments and data to improve the appointment experience notably increasing phone access with a four stage action plan.

Patients could access a male or female GP and those over the age of 75 years had a named GP who was responsible for their care and support. Home visits and telephone consultations were available for patients who required them, including housebound patients and older patients.

Tackling inequality and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointments were available for those with long-term conditions, learning disabilities and those experiencing poor mental health.

Current data on the ethnicity of the local population was not available. However, data from the 2011 census identifies that 98.2% of the local population describe their ethnicity as white British. We were told by the practice that this was reflected on the patient list which was similar to other practices in the locality.

The practice comprises of two buildings. In both buildings all services for patients were on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms. Toilets were available for patients attending the practice, including accessible facilities with baby changing equipment. We noted there was no hearing aid loop in the practice.

Staff told us that they did not have any patients who were of "no fixed abode" and would not know how to register these patients. Staff we spoke with said they had not completed equality and diversity awareness training. Staff confirmed that equality and diversity wasn't discussed at staff meetings.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The surgery was open from 08:00 to 18:30 Monday - Friday. Extended hours were offered from 07:00 to 08:00 on Tuesday-Friday mornings

Information was available to patients about appointments on the practice website but did not reflect the extended hours. Information on the website included how to arrange urgent appointments, home visits, routine appointments and how to cancel appointments electronically. The practice was currently trialling online appointment booking.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one.

Data from GP National Patient Survey and in house patient surveys had been reviewed as patients responded negatively to questions about access to appointments. For example:

- 71% described their experience of making an appointment as good compared to the CCG average of 69% and national average of 74%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 50% said they could get through easily to the surgery by phone which was significantly lower than when compared to the CCG average of 73% and the national average of 74%.

The practice had reviewed how they could improve the appointment experience and increase phone access to meet the demand for appointments at known busy times. The practice used the patient feedback, consulted with practice staff, involved the PPG and implemented four key changes.

For example, the practice now allowed bookings for on-the-day appointments to be allocated at 08.00 for the whole day. Review appointments were implemented, which allowed the reception team to forward book a review appointment. The practice introduced a cancellation list. A new telephone system was introduced which provided the facility to allow patients to queue and be informed of their position in the queue.

Patients we spoke with on the day and comment cards we received were satisfied with the appointments system and how it had improved. One of the patients we spoke with had arrived at the surgery following a cancellation and a phone call from the from the reception team.

They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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. However, there was no information on how to complain on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients we spoke with needed to make a complaint about the practice. They were happy with how the complaint was handled, satisfied with the communication and pleased with the timely outcome.

We looked at 12 complaints received in the last 12 months. The practice could not provide evidence of the complaint being discussed or actions documented. Verbal complaints were not recorded making it difficult to review and identify any trends. There was an annual review of complaints, we were told this was only for the Health and Social Care Information Centre (HSCIC) and not shared with practice staff. We saw no evidence of and internal review process where complaints were systematically reviewed to identify trends and potential learning.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice's vision was not clearly defined. Staff we spoke with were not aware of a vision or strategy and told us it had not been discussed with them. There was no business plan or long term strategy in place. We were told that this was because the plan and strategy could not be agreed by all partners.

Four of the members of staff we spoke with said they did not know or understand the values of the practice. They were not of what their responsibilities were in relation to these and had not been involved in developing them.

We saw that the practice had a recently reviewed (June 2015) documented statement of purpose and included in their aims and objectives 'The provision of good quality primary care services is delivered in a clean suitably equipped safe environment suitable for all patient groups; proactive management of all medical conditions through the use of special clinics; ensuring all members of the Practice team have the right skills, enhanced by continuous training and education to carry out their duties competently". The evidence found at this inspection identified that the practice was not meeting the aims and objectives within their statement of purpose. For example, we identified significant and continuing concerns with infection control and the cleanliness of the environment. Staff were also not receiving the training to support them in their roles.

Governance arrangements

The concerns highlighted on the day of inspection, in relation to governance systems and risk, suggested the changes to management responsibilities were not effective. The lead GP took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. However, we identified evidence which demonstrated how the governance arrangements and their purpose were ineffective and unclear. We saw limited evidence to confirm how the practice monitored their performance.

The practice had a number of policies and procedures in place to govern activity. However, these were not always available to staff. Some of the policies we reviewed were not always up to date and had not been reviewed.

There was team structure with named members of staff in lead roles. For example, there was a GP for infection control and the senior partner was the lead for safeguarding. Other members of the practice management team had been given clearly defined roles relating to IT and reception.

A practice manager had been employed in October 2014 to undertaken practice management responsibilities. The practice had arranged support from an experienced practice manager and two assistant practice managers. The practice manager had attended management meetings organised by the local CCG. However our discussions with the practice manager identified there was a lack of clarity about authority to make decisions. On the day of inspection it was unclear who was responsible for ensuring that actions relating to the operation and maintenance of the building were carried out. This was demonstrated within the evidence collated which identified poor governance and highlighted an ineffective leadership team. Quality and safety were not the top priority for leadership.

The GPs took an active role in overseeing that the systems in place to monitor the quality of the clinical outcomes were consistently being reviewed and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing slightly below national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw several clinical audits including an audit of minor operative procedures and injections between April 2014 and January 2015. We also saw a comprehensive clinical audit on pneumococcal vaccine in patients with coeliac disease. The audits we reviewed were two cycle audits which had been repeated to monitor improvements.

The practice had not consistently identified, recorded and managed risks to ensure the safety of patients, visitors and staff. For example, health and safety risk assessments had not always been undertaken, fire evacuation drills were not

Are services well-led?

Inadequate

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

completed, calibration checks could not be verified and legionella risk assessments or checks were not undertaken. All necessary checks and actions relating to employment of staff had not been carried out.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including the Health and Safety policy and Visual Display Unit (VDU) policy which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

In February 2014 the practice was issued with a Care Quality Commission report which highlighted three regulatory breaches in cleanliness and infection control and monitoring and assessing the quality of service provision. In September 2014 the practice had a second inspection checking actions had been implemented. We found there were further and continued breaches within the regulation relating to cleanliness and infection control and assessing and monitoring the quality of the service. In October 2014 an action plan was received from the practice which outlined the corrective action. For example implementing effective infection control procedures and actions. We found these were not all completed and further breaches were identified at the inspection on the 17 June 2015. The practice also failed to ensure patient information and health records were held securely and could not be accessed by patients or visitors. The security of patient records was highlighted at the previous inspections and appropriate action had not been taken. The practice had not paid full heed to a report compiled by the commission, where action was required.

Leadership, openness and transparency

The GP partners were visible in the practice but the some of the staff we spoke with said they were not clear about their own roles and responsibilities and those of others. They were not always sure who to go to in the practice with any concerns.

We spoke with nine members of staff during the inspection, the majority were positive about the practices leadership. However, three members of staff described that there was no team culture and they felt undervalued. The same three members of staff expressed a low level of job satisfaction and did not feel respected, valued, supported and appreciated.

The practice manager was relatively new in post and expressed a commitment to make improvements. However, they acknowledged having limited support since commencing the role in October 2014 and they were not given backing to implement change, make improvements or make decisions appropriate to their role.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and written complaints received. Actions from the last patient survey had been identified and implemented to improve the service for patients.

It had an enthusiastic and growing PPG which included representatives from various population groups which reflected the patient list. A recent recruitment drive has brought the total number of members to 23. The PPG was newly formed (April 2015) but has started to meet regularly and were in discussion with the practice to identify how the PPG can work to assist and help Green Meadows Partnership provide a better patient experience. We spoke with two members of the PPG and they were very positive about their role felt engaged with the practice.

The practice staff felt they had limited opportunities to provide feedback and suggestions for improvements. Staff told us that they did not feel engaged in practice changes or developments.

The practice had a whistleblowing policy which was available to all staff, but some staff we spoke with were unaware of the specific purpose of a whistleblowing policy. Whistleblowing is where a staff member reports suspected wrong doing or misconduct at work.

Management lead through learning and improvement

There was little innovation or service development. There was some evidence of learning and reflective practice. Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw evidence that the GPs had regular in house educational sessions. They met to share

Are services well-led?

Inadequate

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

information, knowledge and experiences in order to keep up to date with clinical developments. Information was then shared with nurses. In May 2015 one of the GPs led an educational session on ovarian cancer.

However, we saw training records which showed no dates had been entered for mandatory training courses such as safeguarding children and adults and infection control. It was difficult to evidence on the day of inspection which staff had undertaken which training and when. There was not a robust system to manage the update of mandatory training at the appropriate intervals.

We looked at six staff files and saw that regular appraisals had not taken place for a number of years. Some of the staff that we spoke with said that they had previously received annual appraisals and that these were useful. However, the dates of most recent appraisals documented in files ranged from 2008 to 2013. Staff did not have current objectives, training or development plans.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. Learning from events were acted on as soon as possible. For example, we noted that there had been a failure in maintaining the correct fridge temperature and appropriate action had been taken to maintain the viability of the vaccines held. Minutes from meetings showed that all significant events were reviewed regularly to identify any trends.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found the provider had not followed a process to ensure a process of proper and management of medicines. National guidance was not followed in the security of prescriptions.** Regulation 12 (2)(g)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **We found the provider did not operate robust recruitment procedures including** **undertaking appropriate pre-employment checks to ensure persons employed for the purposes of carrying out regulated activity are of good character and have the qualifications, competence, skills and experience which are necessary for their role.** Regulation 19(1) (a) (b) (c) (2) (4).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found the provider did not operate effective systems to ensure staff received appropriate support, training, professional development and appraisal.** Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found the provider had not implemented effective systems to prevent, detect and control the spread of infections. Appropriate standards of cleanliness had not been maintained. Legionella risk assessments and checks had not been undertaken. Infection control audits did not identify the concerns raised at this inspection. This was a continued breach of infection control regulations seen at the previous inspection in September 2014. Regulation 12 (2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured effective systems were operated to ensure compliance against regulation 4 to 20A and remain effective following inspections. The provider had failed to implement effective systems to assess, monitor and improve the quality of service. The provider had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of services users. The provider had failed to securely store service user records. Regulation 17 (2)(a)(b)(c)(f)