Sherwood Rise Medical Centre

Quality Report

31 Nottingham Road, Sherwood Rise, Nottingham,
Nottinghamshire, NG7 7AD
Tel: 0115 962 3080
Website:
www. sherwoodrisemedicalcentre.co.uk

Date of inspection visit: 11 November 2014
Date of publication: 09/04/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 11 November 2014 as part of our new comprehensive inspection programme. This is the first time we have inspected this practice.

This practice has an overall rating of requires improvement and this is because it requires improvement in the safe, effective and well led domains and in relation to how it serves patients with long term conditions.

Our key findings were as follows:

- When things went wrong, lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- Data showed patient outcomes were at or below average for the locality with some evidence of potential risks as a result. For example the number of reviews completed for patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease) was low with a risk that changes to their health would not be picked up in a timely way. Knowledge of and reference to national guidelines were inconsistent amongst clinical staff working at the practice.
- Data showed that patients rated the practice positively in respect of several aspects of care. Patients said they were treated with compassion, dignity and respect and most patients told us they were involved in decisions about their care and treatment.
- The practice staff reviewed the needs of the local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. There had been a marked improvement in patient satisfaction with access to the service since the previous patient survey.
- There were difficulties in the relationship between two partners which we found had a direct impact on the

Summary of findings

quality and consistency of care delivery. This led to patient risk as the systems to assess and monitor the quality of the service and identify, assess and manage risk to patients, visitors and staff were not effective.

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

Importantly, the provider must:

- Ensure there are safe systems in place to enable the provider to protect patients against the risks of receiving inappropriate or unsafe treatment by; ensuring prompt action in relation to test results and letters from other providers where necessary, ensuring patients with a diagnosis of COPD (a lung disease) are identified and reviewed as soon as possible and ensuring parents whose first language is not English have access to information about vaccines in an appropriate format.
- Maintain accurate records in relation to the management of the service and patient care.
- Provide appropriate training to enable the Practice Nurse to fulfil her role in terms of assessing and reviewing patients with COPD and providing education to enable patients to manage their symptoms and maximise their health.
- Ensure there is an effective system in place to enable the senior leadership team to regularly assess and monitor the quality of the service and to identify, assess and take action to manage risks to patients, staff and visitors.

In addition the provider should:

- Ensure all staff have access to essential records such as significant events and clinical and practice meeting minutes and know where these are located
- Risk assess the need for the GP without a criminal records check through the Disclosure and Barring Service (DBS) to have such a check in line with guidance.
- Ensure clinical staff have appropriate clinical supervision to identify any areas of training necessary to fulfil their roles and responsibilities and enable their continuous professional development. Ensure there is evidence to demonstrate that all non-clinical staff have received an appraisal in line with the practice policy and have their training needs identified.
- Identify and take further steps to improve the rates of breast and bowel screening, flu vaccinations and childhood immunisations.
- Ensure there is an effective system for triaging letters coming in from the out of hours service to determine if any action is needed to take to support patients with their health.
- Develop a long term business and development plan to drive and embed the vision and strategy of the practice in order to take a practice wide approach to quality improvement.
- Consult patients about the role and purpose of the PPG and establish terms of reference to ensure there is clarity going forward about their role and purpose.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses.

However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were always kept safe.

For example not all staff took on board learning from significant events and made changes to their practice to prevent the same issues reoccurring. Systems and record keeping in the absence of a practice manager were not sufficiently robust to enable the partners to be assured that they knew of the risks to patient safety and had robust systems in place to address these.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

Data showed patient outcomes were at or below average for the locality with some evidence of potential risks as a result. For example the number of reviews of completed for patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease) was low and meant that symptoms of worsening health may not be identified and treated in a timely way. Knowledge of and reference to national guidelines were inconsistent amongst clinical staff at the practice.

The measures taken by the practice to improve patient outcomes were not always fully successful and more proactive actions were needed in some areas. For example there needed to be more concerted efforts to do outreach work with identified patient communities to improve rates of breast and bowel cancer screening.

There were completed audit cycles of patient outcomes in some areas which demonstrated improvements had taken place.

Multidisciplinary working was taking place but records demonstrating what was discussed and actions being taken were limited or absent.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice positively in respect of several aspects of care. Patients said they were treated with compassion, dignity and respect and most patients told us they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to try and secure improvements to services where these were identified as being needed. The practice had taken effective steps to improve access to the service following poor patient survey results in this area. This had resulted in improvements and patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments and telephone consultations available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence to show the practice learned from complaints and shared the outcomes of investigations with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

The practice had identified aims but not all staff were aware of these and their responsibilities in relation to them. The aims were not being effectively implemented.

There was no clear and defined leadership structure and there were difficulties in the relationship between the GP partners which was negatively impacting on their ability to assess and monitor the quality of the service effectively. Most staff felt supported by management but at times they weren't sure who to approach with issues due to the relationship between two partners.

The practice had a number of policies and procedures to govern activity but governance meetings were not held and there was no forum where identified risks could be brought to the attention of the senior leadership team, discussed and actions agreed. Where changes to practice were needed, the relationship between two of the partners affected the implementation of change.

Summary of findings

The practice proactively sought feedback from patients but the patient participation group (PPG) was not active and had no terms of reference to govern activity and help drive improvements.

All staff had received inductions but not all staff had received regular performance reviews and they did not have clear training and development objectives to enable them to fulfil their roles and responsibilities effectively.

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

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people, though some older people did not have care plans where necessary to ensure their care was co-ordinated when many professionals and agencies were involved.

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 patients living in care homes and those receiving end of life care. It was responsive to the needs of older people, and offered prompt home visits and rapid access appointments for those with enhanced needs.

The practice had signed up to deliver an enhanced service to patients living in care homes. Each care home had a named lead GP who visited once a month. The managers of two care homes told us the GPs were supportive and they said most of the GPs had a kind and caring manner and were very responsive when a visit was needed. Both of the care homes were happy with their lead GP. Patients in care homes had their medicines reviewed on a rotational basis during the planned monthly visits to make sure prescribed medicines were appropriate for the person's needs.

Each person over 75 had a named GP who was responsible for reviewing any discharge letters following admission to hospital. The GPs reviewed patients on multiple medications to make sure these were appropriate and effective.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

Not all patients with long term conditions had a personalised care plan to ensure care and treatment was co-ordinated. As a result of poor quality care planning opportunities were missed to identify patients living with multiple long term conditions to enable staff to assess these together to avoid multiple appointments.

Data showed patient outcomes were at or below average for the locality with some evidence of potential risks as a result. For example the number of reviews of completed for patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease) was low and meant that symptoms of worsening health

Summary of findings

may not be identified and treated in a timely way. There was a misunderstanding between staff at the practice about what should prompt a review of a person's COPD and the staff that were identified by GPs as responsible for carrying out these reviews did not have the necessary training to be able to complete these effectively. Emergency processes were in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

Rates for the standard childhood immunisations were mixed and steps taken to immunise children opportunistically were not wholly successful and there were no other contingency plans in place to increase take up and protect children from common preventable illnesses.

The nurse administered vaccines but told us she did not provide guidance and information about vaccines routinely to parents whose first language was not English. We were concerned about this given the number of patients registered at the practice who did not have English as a first language and the nurse's awareness of this facility being available on the electronic system through EMIS Web. As a result the parents of these patients may not have the information they needed to make informed decisions and ensure they could recognise adverse reactions and take corrective action.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had sustained non accidental injuries or whose parents were the victims of domestic violence.

The practice staff had a policy of seeing any child under 16 on the same day and we observed this happening in practice. Appointments were available outside of school hours and the premises were suitable for children and babies with areas available for mothers to breastfeed in private.

We saw good examples of joint working with midwives and health visitors to keep mothers, babies and children safe before and after the birth. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement 

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

The rates of cervical screening were high at 82%, and the practice was performing better than others in the CCG area in relation to this area. However, their performance in relation to national mammography and bowel cancer screening was below the average of the CCG at 52.5% and 45% respectively. The practice staff knew the rates of breast and bowel screening were low when compared with other practices within the CCG. The GPs felt this was due to a lack of education and understanding about the tests within certain parts of the practice patient community. Practice staff acknowledged they had not fully explored the role of community outreach in trying to maximise the uptake of such tests. More proactive steps needed to be taken to minimise the risks to the patients.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Telephone consultations were available every day between 12:30 and 1:30 and working patients could call and speak with a doctor during that time so that they did not have to take time off work unnecessarily. Working age patients we spoke with valued this service and it was a very positive aspect of the delivery of the service.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability and could identify how many patients were on each register. It had carried out annual health checks for people with a learning disability and the majority of these patients had received a review of their health care needs. Longer appointments were offered for people with a learning disability. We spoke with a patient with a learning disability who said the practice staff were responsive to their needs and they said they could see their preferred doctor who involved them in care and treatment decisions.

Summary of findings

The practice had some patients from the travelling community registered with them. A GP we spoke with told us their open access and telephone services enabled these patients to seek treatment and advice as and when they needed this.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs informed patients from vulnerable patients about how to access various support groups and voluntary organisations such as Last Orders (for alcohol dependency) or Framework (for homeless patients). Staff knew how to recognise signs of abuse in vulnerable adults and children.

The practice staff were well aware of the needs of their vulnerable patients and ensured ease of access and a compassionate approach.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice maintained registers of patients experiencing mental ill health and a patient we spoke with told us they received an exceptionally responsive service from a GP when they had been in crisis which had helped them towards recovery of their mental health. This GP made it a priority to see the patient and offered continuity of care throughout their experience of ill health.

The community midwife told us one of the GPs was very responsive to any concerns she raised about the mental health of women who were pregnant. She also told us the GP was very aware of the possibility of post natal depression and would take responsibility for visiting such patients if she was unable to through leave. The midwife told us she valued the responsiveness of this GP in situations of crisis.

Staff told us the practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and those in crisis. The records of these meetings could be more detailed.

The GPs were responsive to patients experiencing depression and patients and other healthcare professionals told us they responded with compassion and care.

Summary of findings

What people who use the service say

We reviewed the most recent published data available for the practice on patient satisfaction. This included information from the national patient survey from July 2014. A survey of 130 patients was undertaken by the practice's patient participation group (PPG) The evidence showed the practice performed in line with others nationally, in terms of the proportion of respondents who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. The practice was also performing in line with others nationally in respect of the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good.

We looked at the most up to date results from the national patient survey which was sent to 450 patients. 104 patients responded which was a 23% response rate. The practice performed better than others in the CCG in relation to how easy they found it to get through to the practice on the phone (90%), how helpful the receptionists were (96%) and how good the nurse was at explaining tests and treatment (96%). The practice performed less well than others in the CCG in relation to patients feeling involved in decisions about care (61% said this was good), in terms of the proportion of respondents who stated that the last time they saw or spoke to a GP, the GP was good at explaining tests and treatment (68%) and in relation to the percentage of patients who described their overall experience of the service as good (69%).

We received 29 completed comment cards, the vast majority of which were positive about the practice and the service. Patients said they felt the practice staff were friendly; that certain GPs were helpful and understanding, that reception staff were caring and considered that they were listened to and received the right care and treatment.

We also spoke with six patients during the inspection and the majority of those we spoke with were happy with the service and the GPs who they said treated them with dignity and respect.

We spoke with the managers of four care homes and they were complimentary about most of the GPs and said the practice staff were very responsive to their patients and provided excellent end of life care.

Areas for improvement

Action the service MUST take to improve

- Ensure there are safe systems in place to enable the provider to protect patients against the risks of receiving inappropriate or unsafe treatment by; ensuring prompt action in relation to test results and letters from other providers where necessary, ensuring patients with a diagnosis of COPD (a lung disease) are identified and reviewed as soon as possible and ensuring parents whose first language is not English have access to information about vaccines in an appropriate format.
- Maintain accurate records in relation to the management of the service and patient care.
- Provide appropriate training to enable the Practice Nurse to fulfil her role in terms of assessing and reviewing patients with COPD and providing education to enable patients to manage their symptoms and maximise their health.
- Ensure there is an effective system in place to enable the senior leadership team to regularly assess and monitor the quality of the service and to identify, assess and take action to manage risks to patients, staff and visitors.

Action the service SHOULD take to improve

- Ensure all staff have access to essential records such as significant events and clinical and practice meeting minutes and know where these are located

Summary of findings

- Risk assess the need for the GP without a criminal records check through the Disclosure and Barring Service (DBS) to have such a check in line with guidance.
- Ensure clinical staff have appropriate clinical supervision to identify any areas of training necessary to fulfil their roles and responsibilities and enable their continuous professional development. Ensure there is evidence to demonstrate that all non-clinical staff have received an appraisal in line with the practice policy and have their training needs identified.
- Identify and take further steps to improve the rates of breast and bowel screening, flu vaccinations and childhood immunisations.
- Ensure there is an effective system for triaging letters coming in from the out of hours service to determine if any action is needed to take to support patients with their health.
- Develop a long term business and development plan to drive and embed the vision and strategy of the practice in order to take a practice wide approach to quality improvement.
- Consult patients about the role and purpose of the PPG and establish terms of reference to ensure there is clarity going forward about their role and purpose.

Sherwood Rise Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The inspection team included a GP, a practice nurse and a practice manager.

Background to Sherwood Rise Medical Centre

Sherwood Rise Medical Centre is a partnership between three GPs providing primary medical services to approximately 3,500 patients in Nottingham City. Data shows that the percentage of children and older people affected by income deprivation and unemployment is higher than the England average in the practice area. The practice serves a varied ethnic community with approximately 25% of the patient population being from South East Asia and Poland. All of the GPs are multi-lingual but interpreters are used if needed.

There are three GP partners and one part time salaried GP; only one partner works full time. There are two male and two female GPs offering patients a choice of the gender of the GP they see. The practice also employs a full time practice nurse and a part time member of staff with a dual role of receptionist and healthcare assistant. Both of these members of staff are female. The clinical team are supported by six part time administrative and receptionist staff.

The practice is neither training nor a dispensing practice and operates from a single location.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services.

This is the first time we have inspected the practice and that is why we included them in the schedule of inspection.

The practice have opted out of providing out-of-hours services to their own patients and there was information on the website and on the practice answer phone advising patients of how to contact the out of hours service outside of practice opening hours.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them

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.

Detailed findings

How we carried out this inspection

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also spoke with four care homes who worked closely with the practice.

We carried out an announced comprehensive inspection of this practice on 11 November 2014.

During our visit we spoke with a range of staff (including all four GPs; the practice nurse, practice manager and administrative and reception staff). We spoke with 6 patients who used the service and the chair of the patient participation group (PPG). The patient participation group 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. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 29 comment cards where patients and members of the public shared their views and experiences of the service.

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 are provided for specific groups of people and what good care looks like for them. These 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)

Requires improvement

Are services safe?

Our findings

Safe track record

We reviewed safety records, incident reports and some minutes of meetings where these were discussed for the last year. The practice team considered reported incidents, significant events, accident reports and national patient safety alerts in team meetings. There were not many records of team meetings and those we saw did not consistently demonstrate these discussions took place, though we were assured by all of the staff we spoke with that they did happen regularly and could give us examples of events which had been discussed.

We saw evidence to show that complaints were analysed to look for trends and patterns indicating a commitment to learning when things went wrong. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We witnessed staff recording an incident during our inspection and this was done openly and honestly. Staff we spoke with told us that where individuals were highlighted as having made mistakes this was discussed openly and honestly with them and we saw evidence in some significant event records which confirmed this was followed through in practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and incidents. Staff used forms on the practice intranet and sent completed forms to the registered manager; we saw this taking place on the day of our inspection.

We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result which aimed to ensure learning was embedded in practice. Where there were clinical concerns the registered manager told us these would be dealt with in a face to face meeting with the individual concerned. One clinician we spoke with confirmed this took place.

Records demonstrated this system had not always been effective at preventing reoccurrence of the same incident in spite of learning being shared in practice meetings. We brought this to the attention of the registered manager and commissioners to ensure patients were safe.

We were also concerned that three significant events referred to in practice meeting minutes from September 2014 were not recorded or stored in the folder on the shared drive where staff had indicated they were. It was clear from the minutes of the meeting that all three issues had been investigated and lessons learned had been cascaded, but the records were not held together with the other significant events so staff could access these should they need to.

The practice had an alerts procedure in place which indicated that the practice nurse disseminated all national patient safety alerts to all staff and then discussed them in clinical meetings or practice meetings. However the practice and clinical meeting minutes did not demonstrate these discussions took place.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults and could provide a list of patients who were at risk of harm or abuse. Staff we spoke with understood their roles and responsibilities to record and report concerns and they showed an awareness of potential situations of abuse. They all knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding in January 2014.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role in September 2014. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. Red card meetings were held between the lead GP and other healthcare professionals supporting vulnerable children with protection plans in place.

We were shown the system to highlight vulnerable patients 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 or anyone

experiencing or at risk of domestic violence to ensure all practice staff were alerted to the possibility of non-accidental injury to the adult or other vulnerable people in the family.

We spoke with a visiting midwife who held clinics at the practice and she told us she found the practice staff to be really good, well organised and very approachable. She told us she worked with the GPs to support a number of women whose unborn or existing children may be at risk. She told us the GPs were very responsive if there were any safeguarding concerns and always provided reports for child protection case conferences if they were unable to attend. She told us the GPs were very diligent at post natal follow up, especially where there may be any evidence of post natal depression creating risk for the new mother or her child.

There was a chaperone policy, which was visible in the waiting room noticeboard and in consulting rooms. Some staff acted as a chaperone. and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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. This included maintaining vaccines at the right temperature when these were being administered during home visits.

There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff had strengthened their systems and checks following a significant event resulting in the vaccination fridge being left open. The practice nurse had reported the incident and made sure all vaccines were destroyed in case they were unfit for use.

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 practice had received a prescribing visit from the Medicines Management Team from the clinical commissioning group in August 2014. This highlighted the practice were underspending and prescribing efficiently. The GP partners had sent round a memo to all staff following the visiting highlighting areas for action the medicines management team had highlighted to make prescribing more effective.

The nurse administered vaccines but told us she did not provide guidance and information about vaccines routinely to parents whose first language was not English. We were concerned about this given the number of patients registered at the practice who did not have English as a first language and the nurse's awareness of this facility being available on the electronic system through EMIS Web. As a result the parents of these patients may not have the information they needed to make informed decisions and ensure they could recognise adverse reactions and take corrective action.

We spoke with the managers of four care homes with patients registered at the practice. They told us that they had a named GP linked to their care home who visited and reviewed patients and their medication on rotation each month. We received two concerns which we passed on to the registered manager and the service commissioners for them to investigate.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept but these were not consistently completed and in some cases were completed in advance. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Some staff at the practice were not sure whether there was a lead for infection control. All staff were due to complete infection control training in December 2014. The practice contracted with an external company who had undertaken an annual infection control audit in August 2014. There were 47 action points identified where improvements were needed to maintain appropriate levels of cleanliness and to prevent the spread of healthcare associated infections. Most issues had been addressed, but there were eleven items on the action plan which had not been completed

and would not be addressed until the premises were refurbished. There was no clear date for the refurbishment to begin. The outstanding issues included; removing a plug from a sink, putting in splash backs on sinks, repairing an area of flooring and painting the toilet wall. We raised this with the registered manager who confirmed he would look at the action plan and see which ones could be completed ahead of the planned refurbishment.

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,

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We checked and found all disposable items of equipment were within date. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Only portable appliances had been tested and there was no written risk assessment in place to indicate when and if non portable appliances needed to be tested. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment in most cases. For example, proof of identification, references, qualifications, registration with the appropriate professional body and all but one GP had a criminal records check through the Disclosure and Barring Service (DBS) which needed to be progressed to ensure compliance with the law. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We received 29 completed comment cards from patients; of these, four patients commented positively about how easy and quick it was to see a doctor.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

In the absence of a practice manager one of the GP partners had taken the lead for health and safety at the practice, but this had not been fully successful in that not all staff knew who took the lead on these issues. We identified some concerns with health and safety, mainly to do with testing and records. Staff we spoke with confirmed there were no written risk assessments in relation to health and safety issues, although the practice had access to a risk assessment tool to help them grade identified risks to patients and staff. As these risks had not been assessed the partners were not aware of the areas which needed attention.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, the practice had a policy that any child under 16 would be seen the same day. We witnessed this policy in practice during our inspection.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The practice had arrangements in place to manage emergencies. We witnessed an emergency situation in the reception area which was dealt with professionally and calmly by the reception and clinical staff ensuring the patient's health, wellbeing and dignity were preserved.

Records showed that all staff had received training in basic life support in April 2014. 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.

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. 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 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 of a heating company to contact if the heating system failed.

The practice had carried out 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 extinguishers had been serviced. However the records did not demonstrate that fire safety tests such as fire alarms, emergency lighting tests and drills were carried out at the correct intervals.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Most of the GPs we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and told us they accessed guidelines from the National Institute for Health and Care Excellence through local commissioners. The registered manager told us these were discussed at clinical meetings but the minutes of these meetings did not demonstrate that this was done consistently. We also received varied comments from staff as to whether this was the system in place. Where guidelines had been discussed there was evidence in meeting minutes to demonstrate that the clinical practice team had agreed the required actions.

There was mixed evidence as to whether all GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the information we received before our inspection indicated that the practice was an outlier in relation to the ratio of reported (as opposed to expected given the practice demographic) levels of diagnosed Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease). An outlier means the data is significantly different when compared to other practices.

We looked at the reasons for the low prevalence and identified that the practice nurse had not had any training to prepare her for assessing, diagnosing and reviewing patients with COPD. Consequently there was very little education or preventative work with patients who may be at risk of developing the condition, or who were newly diagnosed. Patients who had been diagnosed were not being effectively followed up; the percentage of monitoring and medication reviews was low (less than 50% completed). The practice nurse told us a review was only triggered when a patient ran out of their rescue medication pack comprising steroids and antibiotics. The registered manager was unaware that this was the situation. Patients were being placed at risk of ill health by this failure to effectively diagnose, prevent and monitor their condition.

The practice nurse told us clinical staff did not pro-actively and continually review and discuss new best practice guidelines, but waited for the clinical commissioning group (CCG) to inform them of these. Our review of the clinical meeting minutes confirmed that this happened.

The partners showed us data from the local CCG of the practice's performance data. In relation to effective prescribing the practice performance across the board was above average when compared with other practices. The practice had also completed a review of patient admissions from care homes into hospital with preventable conditions. They had undertaken a review of all recent admissions and established different ways of working with care home managers by being the first port of call. This work had resulted in a 75% reduction in admissions on re-audit. We spoke with the managers from all four care homes who told us they were very satisfied with the care and treatment provided by the practice overall.

The practice used computerised tools to identify patients with complex needs who may need multidisciplinary care plans documented in their case notes. The registered manager showed us a comprehensive care plan template and an example of a completed care plan which was completed well. However, this was not used consistently across the whole clinical team and some clinical staff were not aware of the template. The care plans we saw which were written for people with complex needs who were living with long term conditions were of poor quality, with minimal detail and would not support a co-ordinated multi agency approach towards delivering care and treatment.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

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 showed us seven clinical audits that had been undertaken in the last two years. Three of these were

Requires improvement

Are services effective?

(for example, treatment is effective)

completed audits where the practice was able to demonstrate the changes resulting since the initial audit such as a reduction in the number of unplanned and preventable hospital admissions of patients in care homes.

The GPs told us clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We looked at the progress towards QOF targets and saw the practice were meeting the targets for monitoring patients with heart failure and hypertension, but we noted that there were a number of reviews outstanding for patients who had experienced a stroke, those with Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease), asthma and coronary heart disease. The practice team had discussed the need to help each other meet the targets at a meeting in June 2014 but the specific action needed by named practice staff to enable the practice to achieve these were not clear in the minutes.

This practice was an outlier in respect of the reported prevalence of Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease) and in respect of the percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. The practice staff were aware of this data but were not clear about the reasons for this. The partners understood this was an area for improvement.

The team was making use of clinical audit tools and meetings to assess the performance of clinical staff but not all staff had or were receiving appropriate clinical supervision. The practice nurse had been receiving an appraisal from a non-clinical member of staff. There were areas of training and development needs to do with improving clinical practice which had not been identified and acted upon to ensure the continuous professional development of this staff member.

Staff spoke positively about the culture in the practice around quality improvement and they demonstrated a commitment to continuous improvement, but in the absence of a practice manager this had not been driven forward successfully.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

The practice had achieved and implemented the gold standards framework for end of life 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. We saw minutes of these meetings and examples of multi – disciplinary end of life care plans to ensure people lived and died in the way and place of their choosing.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were favourable for rates of cervical screening when compared to other services in the area, but rates of bowel and breast cancer screening were low when compared with other practices in the CCG area.

Effective staffing

Practice staffing included medical, nursing and administrative staff and our observations and comments from patients indicated they were committed to delivering a positive service to patients. One of the GP partners was the registered manager of the service for the purposes of registration but there was no practice manager taking overall responsibility for the day to day management and organisation of the practice. The absence of day to day leadership had an impact on both performance and potentially safety. For example there was a need for the whole team to work together to increase the volume of patient reviews for those living with long term conditions and to try and encourage the uptake of vaccination, immunisation and bowel and breast screening which were all areas where the practice were performing below others within the local CCG area.

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their

Requires improvement

Are services effective?

(for example, treatment is effective)

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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

We were told that all staff had annual appraisals that identified learning needs from which action plans were documented. There was no record of these appraisals in three of the seven reception and administrative staff files, one was due and a further two were due in January 2015.

The practice nurses had an extended role (for example seeing patients with long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease), diabetes and coronary heart disease) but had not received training to enable her to undertake reviews of patients with Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease) effectively. This was impacting on the volume of reviews and the quality of the education and preventative advice the nurse could offer patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex needs and situations. Staff at the practice 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. There was evidence from significant events and practice and clinical meetings indicating that these systems had not always worked effectively. This had resulted in blood tests not being seen and acted on promptly on two occasions. Following these incidents changes had been made and discussed with the whole practice team.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, community matrons, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and was a means of sharing important information and co-ordinating care and treatment.

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 through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

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. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Our interviews with reception and administrative staff identified that letters coming in from the out of hours service were being processed and scanned onto patients' electronic records without being triaged by a GP. There was a risk that GPs were not aware of important information about patients who may be more likely to use out of hours services, such as those experiencing mental ill health or those whose circumstances may make them vulnerable such as people with drug or alcohol dependency or those with no fixed abode. The registered manager was not aware of this and said he would take steps to address it immediately.

Consent to care and treatment

The practice were flagging as worse than the national average in respect of the proportion of patients from the patient survey who stated that the last time they saw or spoke to a GP, they were good or very good at involving them in decisions about their care. We received mixed feedback from patients in this area. The majority of patient feedback we received was positive about involvement in decision making in respect of care and treatment. Most of the negative feedback was specific to one person in the practice team and this was shared with the registered manager and commissioners to enable them to investigate and take action.

We found that although staff were aware of the Mental Capacity Act 2005 (MCA) they did not have sufficient

Requires improvement

Are services effective?

(for example, treatment is effective)

understanding to apply this to the practical day to day situations faced. The policy on consent did not cover the MCA and staff we spoke with had not received training to help them understand how to assess patients' capacity to consent if they felt this was lacking.

In principle, patients with a learning disability and those with dementia should have been supported to make decisions through the use of care plans, which they were involved in agreeing, though these were not always in place. Managers of the care homes we spoke with gave us mixed views about whether the GPs understood the MCA and the implications of this for their patients and two care homes told us they took the lead in discussions about capacity.

The practice provided contraceptive and family planning services but not all clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical 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.

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 and there was guidance available in a practice policy.

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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic opportunities for vaccination or screening to patients and offering advice to smokers, to older patients about breast screening, bowel screening and to parents about immunisations.

The practice also offered NHS Health Checks to all its patients aged 40-75 and every patient over 75 had a named GP and we saw evidence to show there was a plan for practice staff to advise every patient of this.

The practice had numerous 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 22 patients were on the list. All but 9 had received an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was very high at 82%, which was better than others in the CCG area, and the CCG had highlighted this as very positive given the demographic of the practice population. However, their performance in relation to national mammography and bowel cancer screening was below the average of the CCG at 52.5% and 45% respectively. The practice staff knew the rates of breast and bowel screening were low when compared with other practices within the CCG. The GPs felt this was due to a lack of education and understanding about the tests within certain parts of the practice patient community. Practice staff acknowledged they had not fully explored the role of community outreach in trying to maximise the uptake of such tests. More proactive steps needed to be taken to minimise the risks to the patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice staff knew the rates of flu vaccination and childhood immunisations were low for the CCG and they had attempted to offer opportunistic clinics and to work with health visitors and district nurses. This had not been as successful as anticipated at increasing the vaccination and immunisation rates.

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 national patient survey from July 2014, a survey of 130 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion.

For example, data from the national patient survey July 2014 showed 70% of patients felt the GP was good at treating them with care and concern and 88% of patients said the nurse was and 91% said the nurse was good at giving them enough time and 81% said the GP was.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 29 completed cards and the majority were positive about the service experienced. Patients said they felt the practice staff were friendly; that certain GPs were helpful and understanding, that reception staff were caring and considered that they were listened to and received the right care and treatment.

We also spoke with six patients during the inspection and the majority of those we spoke with were happy with the service and the GPs who they said treated them with dignity and respect.

We spoke with the managers of four care homes and they were complimentary about most of the GPs and said the practice staff were very responsive to their patients and provided excellent end of life care.

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.

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 the reception area did present challenges to maintaining patient confidentiality and some patients raised this as a concern. Staff told us that 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 registered manager.

We observed patients and practice staff interacting with each other throughout our inspection and saw that patients were treated with kindness and respect in all instances. We saw patients routinely being offered chaperones.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients had given mixed views about how involved they felt they were in decisions about their care and treatment. This was based on a sample of 104 returned patient surveys, a 23% response rate.

For example data from the national patient survey from July 2014 indicated there was a difference between the GP and nursing staff in respect of their experience of being involved. 91% of patients reported the nurse was good at listening to them, 96% said they were good at explaining tests or treatment and 80% said the nurse was good at involving them in decisions about their care and treatment. However these figures were lower for patient experience of their GP. 78% of patients reported the nurse was good at listening to them, 68% said they were good at explaining tests or treatment and 61% said the GP was good at involving them in decisions about their care and treatment. That said, 83% reported confidence and trust in their GP.

All but one of the six 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. The majority of patient feedback on the comment cards we received was also positive and aligned with these views.

One patient did not feel their relative had been listened to until they started accompanying them to appointments. Others told us that one GP was not very good at listening or involving them in decisions. Most patients who expressed this concern told us they chose not to make appointments with that GP.

Good

Are services caring?

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 and we saw patients routinely being offered interpreters.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection, the managers of care homes and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required in most cases in a friendly and caring way.

Notices in the patient waiting room, 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population such as improving screening rates for breast and bowel cancer and improving the rates of flu vaccinations and childhood immunisations.

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). For example the PPG had raised concerns about the standard of service patients in care homes received from the practice and as a result a number of initiatives had been put into place. These included; monthly planned visits to each care home with a review of patient medication and health on a rotational basis, having a named GP for each care home and establishing close working relationships with the dementia outreach team, the district nurses and community older people's teams to improve the services provided to patients in care homes.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice staff understood the demographics of the practice population and their needs. The GPs were multi lingual and could offer consultations in a range of languages including; Spanish, Urdu and Punjabi. They also had access to interpreters and we saw staff offer these services to patients to ensure they could communicate their needs effectively and understand any proposed care or treatment.

We spoke with patients whose circumstances may make them vulnerable and they told us the practice staff were responsive to their needs and they felt they had fair access and treatment. The practice had an enhanced services contract to provide services to homeless people and the registered manager could tell us how many patients were registered with them. They also provided services for some asylum seekers and for some patients from the travelling community. The registered manager had a clear understanding of the needs and challenges these patients may have in accessing primary medical services and staff at the practice worked hard to ensure they could access the service when needed. Records we saw confirmed this.

The premises and services could accommodate the needs of people with disabilities as the consulting rooms were on the ground floor with level access. Accessible toilet facilities were available for all patients attending the practice including baby changing and facilities for mothers who were breastfeeding.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

75% of the practice population spoke English though staff could meet the needs of people who spoke different languages through translation services and all of the GPs spoke other languages in addition to English.

Access to the service

The patient survey information from July 2014 indicated that patient's experience of accessing the service had improved significantly. 90% of respondents said they found it easy to get through to the service by telephone, 96% said the receptionists were helpful, 83% were able to get an appointment the last time they tried and 90% said the appointment they were given was convenient for them. These figures demonstrate high levels of patient satisfaction when compared to other practices in the CCG area.

Appointments were available from 08:30 am to 6:30 pm on weekdays. This included a daily slot between 12:30 and 1:30 pm when patients who worked could ring in to speak with a GP without having to take time off unnecessarily. The practice operated an open access appointment system and every patient who needed to be seen was seen on the same day. Appointments with the nurse could be booked a week in advance. All of the patients we spoke with and the managers of the four care homes we spoke with were complimentary about access to the service. We observed

Good

Are services responsive to people's needs?

(for example, to feedback?)

the system in place for appointments and triaging calls and saw that this was handled very efficiently with those who needed to be seen or required a home visit being prioritised.

There was information available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. 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.

Longer appointments were also available for people who needed them and one patient we spoke with told us they attended when it was quiet to avoid becoming upset if the practice was busy. There were appointments available with a named GP or nurse. Home visits were made to four local care homes on a specific day each month, by a named GP and to those patients who needed one. Care home managers told us the GPs would always try and see patients if they needed this outside of these set visit times. They all told us they found the practice staff responsive.

Listening and learning from concerns and complaints

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 on posters to help patients understand the complaints system. 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 had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency in each case.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been discussed at some practice meeting and all staff were able to learn and ensure that changes were acted on.

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 vision to deliver quality care and promote good outcomes for patients but there was no longer term business or development plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values include; to provide the highest level of service in accordance with NHS guidelines; to improve health, wellbeing and educate patients so they can make informed decisions about their lifestyle and to look after their staff. Our evidence during the inspection identified there were some shortfalls in terms of how well the practice was able to fulfil its vision due to a lack of clear management and leadership structure.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 21 of these policies and procedures all had been reviewed annually and were up to date.

All GPs and staff made us aware that there were some difficulties in relationships between partners which we found had a direct impact on the quality and consistency of care delivery. There was no clear operational leadership or checking systems in place. All of the staff we spoke with told us they felt valued, well supported but at times they weren't sure who to approach with issues due to the relationship between two partners. Record keeping standards were not consistent, filing was not adequate and there were no clear audit trails of decision making. This created some risks around succession planning and ensuring a practice wide approach to quality improvement.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was not performing in line with national standards in some areas. The partners were not aware of the reasons for this and consequently there was no effective system in place to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These were not linked into significant events or incidents but there was evidence that some of the completed audit cycles had resulted in significant improvements such as the care home admission audit which had resulted in reduced emergency admissions to hospital for people living in care homes.

The practice had poor arrangements for identifying, recording and managing risks and consequently there were risks to patients which the senior leadership team were not fully aware of. Risk assessments had not been carried out where risks were identified and action plans had consequently not been produced and implemented (for example on health and safety issues, letters from out of hours services not being seen by the GP.) There were no clinical governance meetings to enable the provider to monitor and assess the quality of the service being provided.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We witnessed staff taking responsibility for escalating any issues of concern openly and honestly.

There was strong evidence to show the practice team worked well together, the issues of concern were at senior leadership level.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, their suggestions box and complaints received. The results of the 2013 annual patient survey raised a number of areas of concern, but those for August 2014 were far more positive, especially in respect of access which demonstrated the practice staff had worked hard to improve the service for the benefit of patients.

The practice had a patient participation group (PPG) but this was not currently active and was very small. The last meeting was held in 2013. The PPG had worked with the practice to arrange some sessions to try and educate patients and encourage them to access screening services. There was no constitution or working arrangement for the PPG to govern and direct their work.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Are services well-led?

Requires improvement

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

Management lead through learning and improvement

Staff told us that their clinical professional development through training and mentoring had lapsed. We looked at six staff files and saw that there were no records demonstrating that regular appraisals took place which included a role specific personal development plan. We identified areas where clinical staff needed training and support to effectively fulfil their role and responsibilities.

Staff told us that the partners were very supportive of training and that they were all up to date with their mandatory training.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure there are safe systems in place to enable the provider to protect patients against the risks of receiving inappropriate or unsafe treatment by; ensuring prompt action in relation to test results and letters from other providers where necessary, ensuring patients with a diagnosis of COPD (a lung disease) are identified and reviewed as soon as possible and Ensuring parents whose first language is not English have access to information about vaccines in an appropriate format. Regulation 9(3) (b)-(h)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure there is an effective system in place to enable the senior leadership team to regularly assess and monitor the quality of the service with a view to continuous improvement and to identify, assess and take action to manage risks to patients, staff and visitors. Regulation 17

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must maintain accurate records in relation to the management of the service and patient care. Regulation 17(2)(d)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure the practice nurse has appropriate training to enable them to fulfil their role in terms of assessing and reviewing patients with COPD and providing education to enable patients to manage their symptoms and maximise their health. Regulation 18(2)