Wimbledon Village Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 8.30am on 4 March 2015. The practice had previously been inspected during our pilot phase in May 2014. We must conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

We rated the practice as 'good' for the service providing effective, caring and responsive services, 'requires improvement' for providing safe services, and 'inadequate' for the service being 'well-led'. We rated the practice as 'requires improvement' for the care provided to older people and people with long term conditions and 'requires improvement' for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Overall the practice is rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Patients were satisfied with the appointments system and could get an appointment that was convenient for them.
- The practice had good facilities and was generally well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand.
- The practice did not have a clear vision and strategy and staff we spoke with were not clear about their responsibilities in relation to it.

Summary of findings

- There was no effective system for identifying and managing risks relating to fire safety, and risks associated with infection prevention and control had not been reviewed.
- Some staff described a negative culture within the practice and did not feel comfortable to raise issues.
- Some staff expressed a low level of job satisfaction and did not feel respected, valued, supported and appreciated.
- Patient engagement was limited to responses from the Friends and Family Test (FFT) and opportunistic verbal feedback.

We saw some areas of outstanding practice:

- The practice offered an anticoagulation service which included initiation and peri-operative care for patients taking medicines such as warfarin. Patients could attend the practice to have a blood test (international normalisation ratio [INR]) which measured how well their warfarin medication was working. NICE guidance states that a minimum of 60% of people under the care of an anticoagulation service should be within the therapeutic INR range at a given point in time. The practice had exceeded the target and achieved 75%.

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

Importantly, the provider must:

- Carry out a comprehensive risk assessment to identify, assess and mitigate the risks associated with fire.
- Ensure the use of the large generator in the front office is risk assessed.
- Have evidence to demonstrate that training and assessment of competency have taken place for the health care assistant's role in administering vaccinations, and ensure that they are not in a position where they have to make a stand-alone clinical decision.
- Ensure staff receive training in infection prevention and control and fire safety.
- Involve staff in the appraisal process to ensure their development needs are acted on.
- Ensure induction training is consistently implemented for all new staff.

In addition the provider should:

- Review the infection control audit carried out in December 2014 by NHS England.
- Develop a vision and strategy for the practice and involve staff in its delivery.
- Ensure staff are aware of where all practice policies and procedures are located.
- Ensure topics discussed and actions agreed in staff meetings are recorded and disseminated.
- Review the operation and effectiveness of the practice's patient participation group (PPG) which was inactive at the time of our inspection.
- 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.

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 was rated as requires improvement for providing safe services as there were areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Whilst reviews and investigations were carried out when things went wrong, there was no clear process in place to ensure learning outcomes from incidents were communicated widely to all appropriate staff to support improvement. Not all risks to patients who used services were assessed, and the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, an infection prevention and control audit carried out in December 2014 had not been reviewed and staff had not received training in line with the practice's infection control policy. A comprehensive fire risk assessment to identify, assess and mitigate potential risks associated with fire had not been carried out, and staff told us they had not received training in fire safety. We also found there was a large generator in the front office, a large empty red "jerry can" next to the generator and a smaller red metal fuel can which was half full which posed a potential fire risk. The presence of this in a busy working area had not been risk assessed. The health care assistant (HCA) had also been instructed to administer the flu vaccine during home visits when a GP or nurse was not on the premises and there was no proof of the HCA's competency to respond to an adverse reaction and access to medication to be given in this situation.

Are services effective?

Good

The practice was rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. The practice had a system in place for completing clinical audit cycles to improve performance and patient outcomes. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams. All staff undertook annual appraisals that identified learning needs from which action plans were documented. However, one to one meetings to formally discuss staff performance and development needs had not taken place for four staff we interviewed. We were told that new staff received induction training however it had not been implemented consistently for all new staff.

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Are services caring?

Good

The practice was 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. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was generally 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 to issues raised. Staff were updated on the outcomes of complaints, although we did not see how learning from complaints was disseminated to all staff.

Are services well-led?

Inadequate

The practice was rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. The practice had a number of policies and procedures to govern activity. However, whilst the practice had taken measures to ensure staff were informed of how to locate the policies and procedures, two staff we interviewed were not aware of how to locate them. There was no effective system for identifying and managing risks relating to fire safety, and risks associated with an infection prevention and control audit from December 2014 had not been reviewed. Staff received annual appraisals that identified learning needs, but one-to-one meetings to formally discuss staff performance and development needs had not taken place for four staff we interviewed. Staff described a negative culture within the practice and did not feel comfortable to raise issues during practice meetings or with the manager. Staff told us that concerns raised with other senior staff members were not acted on or resolved to their satisfaction. Some staff felt undervalued, were not involved in

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clinical meetings and were not supported to deliver holistic care to patients. Staff expressed a low level of job satisfaction and did not feel respected, valued, supported and appreciated. There was minimal engagement with patients who use services and staff.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. The practice had a higher proportion of older people, and staff told us there were 15 patients who were over 100 years of age. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. 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, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had an electric car which was used by the health care assistant to carry out a domiciliary service for patients whose condition required monitoring. The practice also looked after patients from six local care homes, and the GP who had lead responsibility for each home visited these patients on a weekly basis and on any day of the week if the need was urgent. All hospital discharge summaries for patients over the age of 75 were reviewed, and the patient seen if clinically indicated.

The provider was rated as good for caring, effective and responsive overall and this includes for this population group. The provider was rated as inadequate for well-led and requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and were offered an annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice offered an anticoagulation service which included initiation and peri-operative care for patients taking medicines such as warfarin. Patients could attend the practice to have a blood test (international normalisation ratio [INR]) which measured how well their warfarin medication was working. NICE guidance states that a minimum of 60% of people under the care of an anticoagulation service should be within the therapeutic INR range at a given point in time. The practice had exceeded the target and achieved 75%.

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The provider was rated as good for caring, effective and responsive overall and this includes for this population group. The provider was rated as inadequate for well-led and requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There were systems in place to identify and follow up children who were identified as at risk, for example, children on the child protection register. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours, and each GP had daily emergency slots allocated for children. Practice data showed that 50% of children requiring an appointment were seen within two hours of contacting the practice, and 97% were seen the same day. The premises were suitable for children and babies.

The provider was rated as good for caring, effective and responsive overall and this includes for this population group. The provider was rated as inadequate for well-led and requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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). There were extended opening hours for appointments and telephone consultations could be booked. However, the practice did not offer online facilities to book appointments or to order repeat prescriptions. Travel vaccinations were administered at the practice, and health promotion material was available.

The provider was rated as good for caring, effective and responsive overall and this includes for this population group. The provider was rated as inadequate for well-led and requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. They regularly worked with multi-disciplinary teams in the care of vulnerable people. Patients with a learning disability were offered longer appointments. The practice had an electric car which was used by the health care assistant to carry out domiciliary visits for patients whose condition required monitoring. Staff knew how to recognise

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signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, and documentation of safeguarding concerns. There was also a system in place for identifying carers, and these patients were offered health checks, and immunisations, and provided with information about how to access various support groups.

The provider was rated as good for caring, effective and responsive overall and this includes for this population group. The provider was rated as inadequate for well-led and requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the care of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Longer appointments were available for those experiencing poor mental health.

The provider was rated as good for caring, effective and responsive overall and this includes for this population group. The provider was rated as inadequate for well-led and requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. We reviewed 22 CQC comment cards which had been completed by patients, data from the 2014 National GP Patient Survey, and patient comments from the Friends and Family test carried out by the practice since December 2014.

Data from the 2014 National GP Patient Survey showed that 91% of respondents described their overall experience of the practice as 'fairly good' or 'very good'. This was above the clinical commissioning group (CCG) average of 80%. Patients also rated the practice higher than others for several aspects of care, including their interactions with the GPs and nurses. Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that staff treated patients with kindness and respect, and maintained confidentiality. Patients also commented positively on access to the service, and told us that they were able to get an appointment when they needed one. The majority of comment cards reviewed were positive and said the practice offered a professional service, and that staff were helpful and caring.

Areas for improvement

Action the service MUST take to improve

- Carry out a comprehensive risk assessment to identify, assess and mitigate the risks associated with fire.
- Ensure the use of the large generator in the front office is risk assessed.
- Have evidence to demonstrate that training and assessment of competency have taken place for the health care assistant's role in administering vaccinations, and ensure that they are not in a position where they have to make a stand-alone clinical decision.
- Ensure staff receive training in infection prevention and control and fire safety.
- Involve staff in the appraisal process to ensure their development needs are identified and acted on.
- Ensure induction training is consistently implemented for all new staff.

Action the service SHOULD take to improve

- Review the infection control audit carried out in December 2014 by NHS England.
- Develop a vision and strategy for the practice and involve staff in its delivery.
- Ensure staff are aware of where all practice policies and procedures are located.
- Ensure topics discussed and actions agreed in staff meetings are recorded and disseminated.
- Review the operation and effectiveness of the practice's patient participation group (PPG) which was inactive at the time of our inspection.
- 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.

Outstanding practice

- The practice offered an anticoagulation service which included initiation and peri-operative care for patients taking medicines such as warfarin. Patients could attend the practice to have a blood test (international normalisation ratio [INR]) which measured how well their warfarin medication was working. NICE guidance states that a minimum of 60% of people under the care of an anticoagulation service should be within the therapeutic INR range at a given point in time. The practice had exceeded the target and achieved 75%.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by two CQC Inspectors. The team included a GP specialist advisor and a practice nurse specialist advisor. They were granted the same authority to enter the registered persons' premises as the CQC inspectors.

Background to Wimbledon Village Surgery

Wimbledon Village Surgery is situated at 35a High Street, Wimbledon, SW19 5BY. The practice provides primary care services through a Personal Medical Services (PMS) contract to 11,000 patients in the local area. Due to changes effecting two neighbouring practices the list size had increased by approximately 1000 patients in the last twelve months. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of the NHS Merton Clinical Commissioning Group (CCG) which comprises 26 GP practices. The practice serves a predominantly older population which is higher than both the local CCG and National averages. The practice staff comprise of seven GPs, including one female GP partner, two male GP partners, four salaried GPs (three female and one male), two nurses, health care assistant, practice manager and a team of reception/administration staff. There are also district nurses and health visitors attached to the practice.

The practice runs a tight "usual GP" system whereby whilst patients are registered with the practice they are encouraged to have just one "usual GP". This is to offer greater continuity of care to the patients.

The practice opening hours are 08:00 to 18:30 with extended hours to 20:00 on Monday and Thursday. The practice is closed at weekends and patients are referred to the local out-of-hours provider or the NHS 111 service.

The practice provides a number of clinics and services including chronic disease on going care and support, childhood immunisations, travel vaccinations, phlebotomy, anticoagulation therapy and a domiciliary service.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service. The practice had previously been inspected during our pilot phase in May 2014, and we have an obligation to conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

Detailed findings

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 March 2015. During our visit we spoke with a range of staff including: three GP partners; two salaried GPs; two practice nurses; a health care assistant; the practice manager; and six reception / administrative staff. We observed how patients were being cared for and sought the views of six patients. We reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the practice's policies and procedures.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used some information to identify risks and improve patient safety. For example, reported incidents and 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. Records were kept of significant events that had occurred and these were made available to us. Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events. We reviewed six significant events that had occurred since February 2014 and found they had been investigated and actioned appropriately. This showed that the practice could demonstrate a safe track record over this period of time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Reported significant events were recorded on an incident form including the details of the incident, action taken, outcome and learning. For example, one incident we reviewed involved an out of date injection administered to a patient. A letter of apology was sent to the patient and staff were instructed to conduct weekly checks on expiry dates to prevent reoccurrence. We were told that incidents were discussed amongst the GPs at clinical meetings. However, there was no evidence in the clinical meeting minutes we reviewed to support this.

During the inspection we asked staff to explain the system in place for disseminating and acting on safety alerts received from external agencies such as the NHS and the National Patient Safety Agency (NPSA). We were told that each individual GP received all alerts and were personally accountable for acting on them. Relevant alerts would then be discussed in clinical meetings which the GPs attended daily. However, there was no evidence in the meeting log we reviewed to confirm this.

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 staff had received relevant role specific training on safeguarding. For example, GPs had received Level 3 child protection training, practice nurses had received Level 2, and non-clinical staff Level 1. One GP and a practice nurse had also received training in safeguarding vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training, and they were able to confirm they knew how to recognise signs of abuse in older people, vulnerable adults and children.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had received Level 3 child protection training and could demonstrate they had the necessary training to enable them to fulfil this role. Safeguarding meetings were held bimonthly and were attended by the practice GPs only. The safeguarding lead told us this was considered acceptable given the very small number of cases, and that they would speak with both the health visitor and social worker if the need arose. We were told that vulnerable adults were discussed at other multidisciplinary meetings. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The practice had safeguarding policies which contained the contact details for the relevant agencies. Whilst the practice had taken measures to ensure staff were informed of how to locate the practice's safeguarding policies and procedures, two staff we interviewed were not aware of where these documents were located or the telephone numbers and names of people to ring should they have urgent safeguarding concerns.

There was a 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 on the child protection register.

There was a chaperone policy which was visible in the waiting room. (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). Two of the GP partners told us that only clinical staff carried out chaperone duties.

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. There were procedures 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 manager informed us of an incident in 2013 when vaccinations

delivered to the practice were not kept at the required temperature. We were told of the actions the practice took in response to the incident, and saw evidence that staff were informed of the incident to prevent a reoccurrence.

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 medicines were disposed of in line with waste regulations. The practice were also involved in a scheme that recycled GP patient returned medicines, which were at least 15 months from expiry, and donated these to health units in Africa. We saw a notice in reception that informed patients of the scheme and the list of medicines which could be sent.

The practice nurses administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance, and we saw up-to-date copies of directions for the two practice nurses had been signed. We were told that the health care assistant (HCA) administered vaccines at the practice and during home visits. A GP partner told us that the HCA was given a printed list of patients that she was asked to visit and administer the flu vaccine. We saw a template of a 'home visit action form' which the practice used as a patient specific direction (A patient specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient). We were told that in-house training was provided by appropriate staff (GPs and practice nurses) to support the HCA in her role, however we did not see evidence of specific training and assessment of competence for the administration of immunisations. Although the HCA told us that she was supervised by a GP when administering certain vaccines (Zoladex), she had administered the flu vaccine during home visits when a GP or nurse was not on the premises. HCAs are unregistered health professionals and may administer vaccines if patient specific directions are in place. However, they should not be in the position to make independent clinical judgements and therefore a nurse or doctor should be on the premises, or there should be proof of the HCA's competency to respond to an adverse reaction and access to medication to be given in this situation.

Repeat prescriptions could be requested in person, via e-mail, by post, or by fax however they could not be requested online. It was the practice's policy not to accept orders over the phone for safety reasons. Patients could then collect their prescription from the practice, a chosen pharmacy, or have it posted. The practice leaflet and website stated it took 48 hours to process repeat prescriptions however, this differed to a notice in the waiting room stating it took 72 hours to process. A member of staff who processed repeat prescriptions told us the turn-around time was usually 48 hours.

Administrative staff generated authorised repeat prescriptions. If there were any changes to a prescription, for example adding a new medicine, this was done by the GPs. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored securely at the practice. A GP partner told us a small number of prescriptions were kept in GPs' bags and these were not currently monitored. This was a recommendation from our previous inspection in May 2014 however had not yet been addressed. The partner agreed that the practice would consider an alternative approach to manage this risk.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. One of the GP partners was in the process of carrying out an audit to check that patients taking methotrexate were being monitored appropriately. The GP had identified eight cases where it was unclear if the patient was being monitored at the hospital, and these patients were contacted as a result. The practice also offered an anticoagulation service which included initiation and ongoing care and support for patients taking medicines such as warfarin. Patients could attend the practice to have a blood test (international normalisation ratio [INR]) which measured how well their warfarin medication was working. NICE guidance states that a minimum of 60% of people under the care of an anticoagulation service should be within the therapeutic INR range at a given point in time. The practice had exceeded the target and achieved 75%.

Cleanliness and infection control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However we did find that the seat in the staff toilet on the first floor was unhygienic and in need of urgent replacement.

Requires improvement

Are services safe?

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 and aprons were available for staff to use. Hand hygiene techniques were displayed by hand washing sinks in treatment rooms, along with hand soap, hand gel and hand towel dispensers.

The practice's infection control policy stated that infection control training would take place for all staff annually, and for new staff members within four weeks of starting with the practice. However, there were no training records that evidenced this and staff we spoke with said they had not received training in infection control. Staff were not clear on who led on infection control and therefore did not know who to report to with any concerns.

The practice had received an infection prevention visit from NHS England in December 2014, and we were sent a copy of this prior to our visit. The audit confirmed the practice had written schemes for prevention of legionella (a bacterium that can grow in contaminated water and can be potentially fatal), and that risk assessments for legionella were being carried out. The audit also referred to areas that required improvement, such as replacing carpets in consulting rooms with impervious easy to clean flooring, arranging for wipe-able chairs which are easy to clean, and de-cluttering of all consulting rooms. When we spoke to the registered manager of the service about the audit they told us they had not seen the report. Following discussion with colleagues, they told us that the practice had received the report but they had not reviewed it.

The practice carried out minor surgery and were sterilising minor surgery instruments in-house using an autoclave. We saw that the autoclave had been tested in line with the practice's schedule for checking equipment. We saw a folder containing details of all sets of instruments that were used for minor surgery and intrauterine device (IUD) fitting so the practice could monitor and track which instruments were being used. The practice nurses told us they assisted the GPs during minor surgery sessions and with sterilisation. They told us all instruments were washed and sterilised, and were able to describe the in-house procedures for sterilisation. We saw records containing the date and time of sterilisation were printed from the autoclave with each sterilisation cycle. We also saw that instruments were placed in sterile bags and colour coded to identify they had been sterilised in line with Public Health England guidance.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was July 2014. Equipment had been tested and calibrated in June 2014, and we saw records to confirm this for equipment such as blood pressure monitors and the electrocardiogram machine.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Criminal record checks had been carried out on clinical staff and it was not practice policy to complete criminal record checks on non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The staff rota was planned two weeks in advance to pre-empt any potential staffing issues. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We were told that there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. For example, there were usually two administration staff and two reception staff per shift in case a staff member was off sick that day. GPs also had paperwork sessions which enabled the cover of other GPs at short notice. The practice did not use locums at the time of our inspection.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines management, equipment, and dealing with emergencies. The practice also had a health and safety policy. However, we did not see evidence of a comprehensive fire risk assessment that identified, assessed and mitigated potential risks associated with fire. Staff told us that they had not received training in fire safety, and that there were no regular fire drills. On inspection we noted a large generator in the front office. We also noted a large empty red "jerry can" next to the generator and a smaller red metal fuel can which was half full. The presence of this in a busy working area had not been risk assessed and posed a potential fire risk to patients and staff.

We also found that there was no risk assessment in place to mitigate risks associated with the use of the stair lift which was used to transport disabled patients to the first floor where there was room used by a private physiotherapist who would treat some patients with mobility problems.

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 on an annual basis. Emergency equipment was available including access to medical 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 anaphylaxis. 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 'disaster recovery plan' was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of the premises, power failure, and incapacity of staff. The document also contained relevant contact details for staff to refer to. For example, contact details of the supplier of the electronic patient record system should there be a failure to the system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs we spoke with confirmed that guidelines were disseminated and the implications for patients were discussed and required actions agreed. These actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs told us that they were individually responsible for all the specialist clinical areas under the QOF such as diabetes, hypertension and chronic obstructive pulmonary disease (COPD). The practice nurses told us that they were not involved in providing treatment and support on a routine basis for patients with chronic diseases.

The practice monitored their performance in a number of areas including A&E attendances, referral rates to secondary care and antibiotic prescribing. The practice had low referral rates for a number of conditions. These included referrals to gynaecology, orthopaedics, urology and paediatrics which were below both local and national averages. Accident and emergency attendance data were also below local and national averages. The practice's antibiotic prescribing was monitored by the Clinical Commissioning Group (CCG) and compared favourably with other local practices.

Effective systems in place for referring patients to hospital and other health care professionals. We found the practices referral process was efficient and in line with national guidelines including two week wait urgent referrals for suspected cancer. Patients told us that the GPs had a willingness to refer for specialist treatment when required and that the practice were efficient in arranging this for them. 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.

The GPs told us that they adhered to a "usual GP" system, whereby all patients were registered with a particular GP. The GPs would regularly monitor their registered lists to identify if there were outstanding actions to be undertaken. We saw one of the GP partners' QOF monitoring tool, which also identified how every other GP in the practice and the practice as a whole were performing compared to the national average. The GPs met daily to discuss clinical practice and there was a log of the topics discussed.

Management, monitoring and improving outcomes for people

The practice had scored favourably in their Quality and Outcomes Framework (QOF) performance in 2013/14 achieving overall 94% which was equal to the CCG average and slightly above the national average. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. The practice had maximised their QOF points in a number of clinical areas including asthma, cancer, palliative care, rheumatoid arthritis and osteoporosis. The practice's exception rate for 2013/14 was 5% which was below the local and national averages. (QOF allows for exception reporting to ensure practices' are not penalised, where, for example patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side effect).

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included audits of the diagnosis of prostate cancer, urinary tract infections (UTI), osteoporosis and the interaction of cholesterol lowering drugs with other medicines. Most of the audits we reviewed were completed audit cycles in that the audits had been repeated to monitor improvements. We also reviewed an audit of the use of a clinical tool for calculating the risk of stroke in patients with atrial fibrillation (a condition that causes an irregular heart beat) in line with NICE guidelines. Whilst carrying out the audit it had been identified that the practice software was miscalculating risk scores. The practice had informed the software manufacturer as this would affect every GP practice using this particular software resulting in potential adverse outcomes for patients nationally. We saw evidence that the software manufacturer had sent a note of acknowledgment to the practice however the underlying problem had still to be addressed.

Good

Are services effective?

(for example, treatment is effective)

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used that in their learning.

The practice had 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 examples of how care plans were completed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. The GPs had attended a variety of update courses including courses in men's health, sexual and reproductive medicine, family planning and diabetes. One GP had the lead role for end of life care with a special interest in the frail elderly. Another GP had extensive experience in gynaecology and specialised in contraceptive implants and was up to date with the nationally recommended training requirements. In addition three GPs specialised in minor surgery.

All GPs were professionally registered with the General Medical Council (GMC) and nurses with the Nursing and Midwifery Council (NMC). Both practice nurses were Registered General Nurses (RGNs) who had previously worked in a local hospital and one practice nurse had a Diploma in Health Care Practice.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. However, four out of six staff members we interviewed told us that although they were asked to complete an appraisal form, one to one meetings had not taken place to formally discuss staff performance and their development needs.

We were told that staff received induction training when they started working for the practice. However the induction process had not been consistently implemented for all staff, one staff member recently employed by the practice told us that their induction had not been comprehensive and did not cover basic topics such as the fire evacuation procedures.

The health care assistant carried out flu vaccinations and we were told that they had received in-house training. However, we did not see evidence of the specific training undertaken or assessment of competence for the administration of vaccines.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, the NHS 111 service and ambulance services were received in paper form. The GP seeing these documents and results was responsible for the action required. If a GP was on leave, the GP partners would take responsibility to distribute the work so that all correspondence was reviewed and actioned. One GP chose to access the practice system remotely when on leave to review his patient's results. The effectiveness of this could not be audited. All staff we spoke with understood their roles and said the system in place worked well.

The practice had a process in place to follow up patients who were over the age of 75 or from nursing homes, who had been discharged from hospital. An administrator collated this information and it was reviewed by a GP partner. Patients who required clinical input were contacted for a follow-up appointment.

The GPs attended monthly palliative care meetings and worked with district nurses to provide effective care to older patients. The practice had strong links with the local hospice and was providing support to a local care home which had achieved recognition as being an end of life care beacon. The practice held bimonthly safeguarding meetings to discuss children on the at risk register. At the time of our inspection the practice had only one child on the at risk register. Due to the low number of cases, safeguarding meetings were not attended by a health visitor or social worker. However, the safeguarding lead said they would always speak with the relevant professionals if the need arose.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had been 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's Act 1989 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they would be implemented in their practice if needed.

Patients with a learning disability and those with dementia were supported to make decisions. When interviewed, 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. For example, the importance of involving the next of kin for patients with advanced dementia.

GPs demonstrated an understanding of Gillick competences (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge).

Health promotion and prevention

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. There were currently eight patients on the register, and the practice met with the local care coordinator to discuss these patients. The practice had opted not to sign up for the Directed Enhanced Service for Learning Disability and had not seen all those on the register for an annual health check.

The practice's performance for cervical smear uptake for 2013/2014 was 77%. A designated member of staff dealt with recalls, and there was a procedure to remind patients to attend for cervical smears. An initial letter was sent out, and if the patient had not responded they would be contacted by phone, and then a final letter. New patients between the ages of 25 – 65 were also offered a smear test if they had not received one within the last three years. We saw a reminder had been circulated to administration staff to remind them of this, and staff we spoke to confirmed this was taking place. The practice did not routinely offer all new patients a health check and had opted not to offer NHS Health checks for those aged 40-65. All new patients were offered a urine analysis when registering with the practice.

The practice offered personalised care to meet the needs of older patients and patients whose circumstances may make them vulnerable. The practice looked after patients from four nursing homes and two care homes. These patients had a named GP, and the GP who had lead responsibility would visit these patients on a weekly basis or more frequently if clinically indicated. The practice had a higher proportion of older people, and staff told us there were 15 patients who were over 100 years of age. The practice had an electric car which was used by the health care assistant to carry out domiciliary visits for patients whose condition required monitoring. The service included offering blood pressure checks, blood tests, and administering vaccinations to patients. We were told that the practice hoped that the HCA would soon be able to give a small number of patients their regular Zoldadex injections in their own home (Zoladex is an injectable medication used in the treatment of cancer of the prostate). To date all home injections of Zoladex had been given by one of the GPs, or the HCA under the supervision of a GP.

Clinical staff provided opportunistic health promotion advice during consultations. One GP told us that the practice promoted patient self-monitoring, and that patients could email results / pictures to the practice. For example, we were told of a case when a patient had sent a picture to their GP to query their condition. The GP sought specialist advice from a surgeon and was able to advise the patient accordingly. This had resulted in a very satisfactory outcome for the patient.

The health care assistant offered smoking cessation advice and we saw evidence that they had received training to carry out this role. The waiting room and treatment rooms had health promotion information on display, and there were also leaflets available for patients to take away. There was information signposting patients to sexual health clinics, and we saw notices encouraging patients aged 16-24 to undergo testing for chlamydia.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We were shown the immunisation rates for all standard childhood immunisations were over 90%.

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 2014 National GP Patient Survey, and the Friends and Family Test (FFT) implemented by the practice in December 2014.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the 2014 National GP Patient Survey showed that 91% of respondents described their overall experience of the practice as 'fairly good' or 'very good'. This was above the clinical commissioning group (CCG) average of 80%. The practice was also above the CCG average for patient satisfaction scores on consultations with the GPs, with 94% of respondents saying the GP was good at listening to them (CCG average 86%) and 91% saying the GP gave them enough time (CCG average 82%). Satisfaction scores for consultations with the nurses showed that 71% of respondents said the nurse was good at listening to them (CCG average 73%), and 77% said the nurse gave them enough time (CCG average 74%). Comments from the FFT showed that patients were highly satisfied with the care they received and described clinical staff as caring and professional.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent and professional service, and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains or screens 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. An administration office was located away from the reception desk which helped keep patient information private. The reception desk had a partition and one receptionist told us that this space was used if patients wanted some privacy when speaking to reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained when there were a few patients waiting at the reception desk. Staff also told us that consultation rooms were utilised to prevent patients overhearing potentially private conversations between patients and reception staff. Comments from the FFT showed that patients responded positively about their interactions with reception staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

A public address system was used to alert patients when the clinician was ready to see them. The announcement stated the patient's name, which clinician they were seeing, the room number, and the location of the room (i.e. upstairs or downstairs). We observed three clinicians personally accompanying patients from the waiting room to the consultation / treatment room, and noted that this was done for patients in different age groups. We also observed one clinical member of staff escorting a patient with mobility difficulties from the treatment room back to the waiting room, ensuring the patient was comfortable before they left.

Care planning and involvement in decisions about care and treatment

The 2014 National GP 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, 82% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area values of 73% and 80% respectively.

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. Clinicians were praised for their caring approach and patients wrote that they were given enough time during consultations and felt listened to.

Staff told us that translation services were available for patients who did not have English as a first language. We did not see notices informing patients this service was available. We spoke to a receptionist and the practice manager who told us that translation services were seldom used and that in their time of working at the practice they had never needed to book an interpreter for a patient.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection told us they received emotional support from the practice. Comment cards we received also highlighted that staff were caring when patients needed support with newly diagnosed or long-term conditions.

Notices and leaflets in the patient waiting room told patients how to access a number of support groups and organisations. The practice currently had 19 patients registered as carers, and the practice's computer system alerted GPs if a patient was a carer. We were told that carers were offered telephone consultations with the GPs, and if the matter was urgent the call would be prioritised. Reception staff could also send instant messages via the practice's computer system so that GPs were aware of any urgent issues. Staff were aware of patients' needs and told us that carers were offered an annual health check and certain vaccinations, such as influenza and hepatitis B. We saw that 13 patients registered as carers had received the flu vaccination, and two had declined. We also saw written information in the waiting room available for carers to ensure they understood the various avenues of support available to them.

The practice manager told us that if families had suffered a bereavement, their usual GP and the practice sent a letter of condolence. Patients were also offered referral to emotional support services, such as Improving Access to Psychological Therapies (IAPT), who were based within the same building. Staff also told us that many patients were more likely to access privately funded counselling and psychological services. There were notices and leaflets available in the waiting room signposting patients to bereavement support services in the local area.

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 patient'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. For example, there was a very high elderly population. To meet their needs the GPs attended multidisciplinary meetings to plan care for older patients, had lead roles in delivering end of life care, and provided services for six care homes in the local area.

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. One GP we spoke to was the locality lead for the local CCG and attended regular locality meetings.

There had been very little turnover of GPs over the last few years which enabled good continuity of care and accessibility to appointments with a GP of choice. 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. The practice had introduced special children's appointments as a CCG initiative to reduce A&E attendances. Home visits and telephone consultations were available for patients who required them, including housebound patients and older patients.

Tackling inequity 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.

The practice had access to an online interpreter service for those patients whose first language was not English to help them with their communication needs and longer appointments were available for them.

The premises and services had been adapted to meet the needs of people with disabilities including a ramp at the main entrance and toilet facilities to accommodate wheelchair users. There was sufficient space in the patient waiting area to accommodate wheelchairs, mobility scooters and prams and baby changing facilities were also available. There was also a stair lift available to ensure disabled patients could access the first floor consultation rooms.

Access to the service

The practice was open 08:00 – 18:30 every weekday. Extended hours were offered from 18:30 – 20:00 on Monday and Thursday, and staff told us that all patients (not only patients with work commitments during the day) made use of these appointments. The practice's opening hours were displayed in the waiting room, practice leaflet, on the entrance door, and on the website. The practice no longer closed from 12:45 – 13:45, and there was a notice near the reception desk and on the website informing patients of this change. This change had been put in place since the CQC inspection from May 2014 and as a result of patient feedback. Patients could book an appointment over the phone or in person. The practice did not offer online facilities to book appointments. We spoke to a GP partner about this and they told us that there was not a Nationally approved online booking system and this was why the practice did not offer online facilities to book appointments. The GP was a member of a national committee that assessed the safety of all GP IT systems. Informed by this GP's views the practice had decided not to offer online appointments or online access for repeat prescription requests.

The clinical sessions offered by individual GPs was advertised in the practice leaflet and on the website so that patients were made aware of the times they could see their preferred GP, and if this was not possible the other GPs on duty.

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 patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four nursing homes and two residential care homes by a named GP, and to those patients who needed one. Telephone consultations were available daily.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. For example, data from the 2014 National GP Patient Survey showed that 93% of practice respondents said they were able to get an appointment (CCG average 83%), and 90% said the appointment was convenient for them (CCG average 89%). Patients we spoke to told us they could usually get an appointment within four days.

We saw on the appointment booking system that individual GPs had morning, afternoon and 'child' emergency slots allocated each day to accommodate emergency appointments. Patients told us they could see a doctor on the same day or within 24 hours of contacting the practice if it was urgent. One patient who had two children told us that their children had always been seen the same day of requesting an appointment. Patients who left comments on the Friends and Family Test said they could get an appointment quickly if needed. The practice had also analysed the length of time it took patients to receive an appointment. For example, since October 2014 50% of children requiring an appointment were seen within two hours of contacting the practice, and 97% were seen the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. If the complaint was of a clinical nature, this was forwarded to a clinician for investigation and response.

We saw that information was available to help patients understand the complaints system. A summary was made available in the practice leaflet and on the website. The full complaints procedure was also on display in the waiting room.

Patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, all patients told us they would speak to the receptionists or GPs if they needed to make a complaint about the practice. None of the patients we spoke with had ever needed to make a complaint.

We looked at seven complaints received in the last 12 months and found six of these had been responded to by either the practice manager or a GP. One complaint was awaiting the patient's response and was still to be pursued by the practice. Another complaint was being reviewed by an external organisation, and the practice manager told us this related to a member of staff who previously worked at the practice.

The practice reviewed complaints annually to identify any learning outcomes. We looked at the report for the last review where the practice had documented the outcome of the complaint, however there were no learning outcomes identified. One partner told us that the practice learnt from complaints when appropriate. The practice manager told us that learning from complaints was discussed at the daily clinical meeting or the bimonthly administration meeting. The practice manager also sent memoranda to administration staff to update them on the outcomes of complaints they needed to be aware of. Staff were required to sign the memorandum to confirm they had read the information, and we saw evidence to confirm this was taking place. However, we did not see how learning from outcomes of complaints was disseminated.

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 and strategy was not clearly defined. We were informed that it was difficult to articulate a strategy as there was a great deal of change happening in the Clinical Commissioning Group (CCG) and neighbouring practices which had led to approximately 1000 new patient registrations in the last 12 months. There were mixed views between the GPs on whether the practice should federate with others in the CCG. There was also an aspiration to become a training practice which was being actively discussed amongst the GPs. Staff we spoke with were not aware of a vision or strategy and told us it had not been discussed with them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a folder, and on the desktop on any computer within the practice. Whilst the practice had taken measures to ensure staff were informed of how to locate the practice's policies and procedures, two staff we interviewed were not aware of where these documents were located. Some policies, including the infection control policy and safeguarding policy did not have details of when they were created or when they were due for review.

The leadership structure consisted of three GP partners. There were named members of staff in some lead roles. For example, one of the partners and a salaried GP were the leads for minor surgery, and another salaried GP was the lead for safeguarding. The practice manager was the lead for human resources and handling complaints. Staff we spoke with were clear about their own roles and responsibilities but were not always clear on who to report to with specific concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with the CCG average and slightly above the national average. The GPs shared responsibility for QOF and told us they discussed QOF performance in meetings. However, there was no evidence from meeting minutes to confirm that QOF was discussed and strategies implemented to maintain or improve performance.

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 included audits related to medicine interactions and specific diseases including osteoporosis and prostate cancer. Most of the audits we reviewed were completed audit cycles in that the audits had been repeated to monitor improvements.

We were told that partners meetings were held every six to eight weeks. We looked at the minutes of eight meetings held since 2013. The meeting minutes we reviewed were not detailed and we found little evidence of governance topics discussed. For example discussions around performance, quality and risk were absent. We found meeting minutes were generally brief and lacked clarity on topics discussed and reviewed.

Leadership, openness and transparency

It was clear during our inspection that staff did not work as a single team; there were two distinct staff groups. Some staff told us that there was a negative culture within the practice and they expressed a low level of job satisfaction. They told us they did not feel supported in their job and did not feel comfortable raising issues in staff meetings or directly with the manager.

Staff had been informed in writing by the practice manager that a GP's sick note was required for any absence of greater than one day due to ill health. This advice went against national policy allowing an individual to self-certify for the first seven days of an illness. This practice policy was not liked by staff.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment and selection policy. These were in place to support staff, however some staff were not aware of where the policies were located.

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

The practice had gathered feedback from patients through the Friends and Family Test (FFT) implemented by the practice in December 2014. There was a poster in reception stating how patients could leave feedback, which was by completing a questionnaire at the practice, using an electronic tablet in the waiting room, or online. The practice manager told us changes the practice had made

Are services well-led?

Inadequate

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

as a result of feedback. These included extending the practice hours through lunchtime, improved telephone lines, and both front and back reception staff to take calls to cope with demand.

The practice had a virtual patient participation group (PPG) which comprised of four members. We were told the practice had not recently met with the PPG and it was currently inactive. We saw evidence of the last PPG survey carried out in 2011/12. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through annual appraisals. However there was no evidence that staff feedback was acted on. Patient engagement was limited to responses from the Friends and Family Test (FFT), and opportunistic verbal feedback which could not be evidenced.

Management lead through learning and improvement

Staff told us that they did not feel supported. We looked at staff records and saw that regular appraisals took place. However, four non-clinical staff informed us that although they had been asked to complete an appraisal form, the practice had not conducted one to one interviews with them to discuss their performance and development needs. We were also told that nursing staff were not included in clinical meetings.

The practice had completed reviews of significant events. However there was no evidence from meeting minutes that these were shared with staff to ensure the practice improved outcomes for patients. We found limited evidence of learning and reflective practice.

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 that people who use the services and others were not protected against the risk of unsafe care and treatment because: there was no evidence to demonstrate the health care assistant's competency in administering vaccinations and a comprehensive risk assessment for fire safety had not been carried out. This was in breach of regulation(s) 13 & 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 that staff were not adequately supported because induction training was not consistently implemented for all new staff, there was no evidence to demonstrate training in infection control and fire safety and not all staff were involved in the appraisal process to ensure their development needs were acted on. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.