Dr P Oza and Dr R Nam

Quality Report

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Date of inspection visit: 7 July 2015
Date of publication: 17/09/2015

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?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
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 carried out an announced comprehensive inspection at Dr P Oza and Dr R Nam on 7 July 2015. Overall the practice is rated as requires improvement.

Specifically we found the practice to be inadequate for providing safe services, good for responsive services and requiring improvement for providing effective, caring and well-led services. The concerns that led to these ratings apply to everyone using the practice including the population groups.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example in respect of recruitment checks, infection control, the safety of medical consumables and fire safety.
- Patients were at risk of harm because the practice did not have oxygen on site in case of medical emergencies.
- Although the practice had carried out a number of clinical audits, these were not always completed audits and we were concerned about the clinical outcomes for patients experiencing mental ill health given the high rate of exception reporting and high level of prescribing of hypnotics.
- Patients said they were treated with compassion, dignity and respect but the national patient survey results indicated improvements were needed in terms of GPs treating patients as partners in their care and involving them in decision making.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Access was good and urgent appointments were usually available on the day they were requested.
- The systems in place to ensure good governance were not robust and effective and the provider could not be assured that risks to patients, staff and others were identified, assessed and managed effectively.

However, there were also areas of practice where the provider needs to make improvements.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there are effective systems in place to enable the provider to identify, assess and manage risks to patients, staff and others.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure there is a process in place to check medical consumables are within date and safe for use.
- Ensure procedures for dealing with emergencies on site are robust.

In addition the provider should:

- Ensure audits of practice undertaken are completed cycles of audits.
- Ensure actions identified from the infection control audit are completed.
- Take more robust action to ensure patients experiencing mental ill health have the health checks necessary to maintain their wellbeing.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Patients were at risk of harm because systems and processes were not in place to keep them safe. For example the practice had not undertaken any risk assessments in relation to the premises, equipment or the environment. The practice did not have robust arrangements in place for dealing with medical emergencies, for example the practice did not have oxygen on site.

The practice could not demonstrate that it had undertaken appropriate recruitment checks on staff or demonstrate that it had a system in place for checking professional registration and competence of clinical staff.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

Data showed some patient outcomes were at or above average for the locality. For example the practice had had exceeded its target for annual health checks completing 122% of its target for annual health checks which was above the CCG average of 96%.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. However we were concerned about the high exception reporting for patients experiencing mental ill health and more robust steps were needed to ensure patients had regular checks on their physical health to ensure their wellbeing.

Non clinical staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. We saw evidence of robust appraisals for non-clinical staff, however appraisals we saw for clinical staff were not detailed or robust.

We saw evidence of staff working with multidisciplinary teams.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

Summary of findings

Patients told us they were treated with dignity and respect and most felt involved in their care and treatment. We received seven completed comment cards which were all positive. Patients described staff as being friendly and helpful. However the national patient survey data from January 2015 indicated that patients did not feel GPs involved them in their care and treatment decisions, and did not always explain their tests and treatment well. The scores in these areas were lower than the CCG and national averages.

The practice had systems in place to identify and support carers and provided newly registered carers with information packs.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and planned services in accordance with this.

Patients we spoke with told us they found it easy to make an appointment with a named GP and that urgent appointments were available on the same day. 70% of respondents said they usually got an appointment with their preferred GP (compared to a CCG average of 54%). Comment cards, which had been completed by patients, reflected this view. The practice offered a high number of consultations and the practice felt that patients seeing their preferred GP meant an increased continuity of care.

The practice had an active patient participation group (PPG) who told us about improvements the practice had made in response to identified priorities. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised.

Are services well-led?

Requires improvement

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

The practice did not have sufficient leadership capacity to ensure there were robust and effective systems in place which assured safe and effective governance and oversight. The practice did not have robust systems in place to assess risk to patients and staff

Not all staff were clear about the vision or strategy and their responsibilities in relation to it. Most staff felt supported by management.

The practice had a number of policies and procedures to govern activity but some of these were absent, not followed or overdue a review.

Summary of findings

The practice proactively sought feedback from patients and had an active patient participation group (PPG). Administrative staff received regular appraisals and had clear objectives.	

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 provider was rated as requires improvement overall. The concerns which led to this rating apply to everyone using the practice, including this population group.

The practice offered a named accountable GP for all patients aged 75 and over. Patients at high risk of unplanned hospital admissions received same day GP contact and were reviewed with three days following discharge from hospital admissions. The practice maintained a falls risk register.

People with long term conditions

Requires improvement

The provider was rated as requires improvement overall. The concerns which led to this rating apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. All identified patients had care plans in place to ensure a co-ordinated approach to preventing hospital admissions. Longer appointments and home visits were available when needed. The practice offered annual reviews for patients in this group who needed them. For example, 83.9% of patients with diabetes had foot examination in the last 12 months. For those patients who had complex needs, practice staff demonstrated a multi-disciplinary approach to care.

Families, children and young people

Requires improvement

The provider was rated as requires improvement overall. The concerns which led to this rating apply to everyone using the practice, including this population group.

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 were subject to child protection plans. The practice was performing better than the CCG average for childhood vaccinations and immunisations although these were not available when the nurse was on leave resulting in a delay for patients.

The practice offered same day appointments for patients who required emergency contraception.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement overall. The concerns which led to this rating apply to everyone using the practice, including this population group.

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 offered online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice offered immunisations and vaccinations including travel vaccinations. The practice had late opening one evening and one Saturday per month. Practice patients could also access walk in services on a Saturday morning and Wednesday evening provided in a nearby health centre in accordance with a local agreement. Pre-bookable appointments were available for doctors and nursing staff.

They practice offered NHS Health Checks to patients aged 40-75 years of age and had performed 148 health checks in the previous year. This represented 122% of the practice target.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement overall. The concerns which led to this rating apply to everyone using the practice, including this population group.

The practice held a register of patients with a learning disability and 94% of patients on the register had received or been offered an annual health check. The practice had system in place to identify vulnerable people and this was flagged on patient records.

Practice staff had all received training on safeguarding adults and knew how to recognise signs of abuse. Staff had recently completed training in relation to domestic violence and learning disabilities.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider is rated as inadequate for people experiencing poor mental health (including people with dementia).

Data provided by the practice indicated that 100% of patients with dementia had been reviewed in the previous 12 months (the practice had 16 patients on its dementia register at the time of the inspection). However, the most recently published data showed that the practice had a clinical exception rate for depression, mental health and dementia which was significantly above the CCG and national average. Therefore we were not assured that these patients had received essential health checks to maximise their wellbeing. In

Summary of findings

addition, we were concerned about the practice rates of prescribing for hypnotic medicines. For example the average daily quantity of hypnotics for specific therapeutic group age-sex related prescribing unit was 0.64 compared with a national rate of 0.28. The practice did have a higher rate of clinical prevalence for depression than the local average.

The most recently published data indicated that the 100% of patients with a mental health condition had a comprehensive, agreed care plan documented in their records. However, the practice rate of exception reporting in relation to this was 34.4% which was 16.4% above the CCG average and 21.1% above the national average.

The practice did have a clinical prevalence rate for depression which was 6.66% above the local average. The clinical exception rate for mental health was 0.2% above the local average.

Summary of findings

What people who use the service say

We looked at the results of the national patient survey from July 2015. Questionnaires were sent to 371 patients and 109 responded. This was a 29% response rate. The practice performed well when compared within others in the CCG in respect of the following areas;

- 70% of respondents with a preferred GP usually got to see or speak to that GP (compared to a CCG average 54% and national average of 60%);
- 81% described their experience of making an appointment as good (compared to a CCG average of 72% and national average of 73%);
- 80% of respondents said they found it easy to get through to the practice by telephone (compared to a CCG average of 67% and national average of 73%).

The practice did not perform as well in the following areas;

- 73% of respondents said the last GP they saw or spoke to was good at treating them with care and concern (compared to a CCG average of 83% and national average of 85%);
- 77% of patients said the last GP they saw or spoke to was good at listening to them (compared to a CCG average of 86% and national average of 89%);
- 69% said the last GP they saw or spoke to was good at involving them in decisions about their care (compared to a CCG average of 79% and national average of 81%).

We reviewed comments from NHS choices. There were eight reviews of the practice and seven ratings. The rating for the practice on the NHS choices website was 3.5 stars out of a possible five. There were five reviews left in the last 12 months, three of which were positive.

The practice was aware of areas for improvement and worked with the patient participation group (PPG) to identify how these could be made. (A PPG is a group of patients who work together with the practice to improve the care for patients.) The areas identified for improvement were; increased availability of pre-bookable appointment slots, raised seating in the waiting area and use of a TV to raise patient awareness of services provided in the practice and externally.

We received seven completed comment cards. These were largely positive about the services offered by the practice and praised the staff. Two patients highlighted care they had received for specific health conditions. Two cards contained negative comments in relation to availability of appointments when a GP was on annual leave.

We spoke with six patients (including two members of the PPG) on the day of the inspection. Patients we spoke with told us is was generally easy to access an appointment and they were usually seen on the same day.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there are effective systems in place to enable the provider to identify, assess and manage risks to patients, staff and others.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure there is a process in place to check medical consumables are within date and safe for use.
- Ensure its procedures for dealing with emergencies on site are robust.

Action the service SHOULD take to improve

- Ensure audits of practice undertaken are completed cycles of audits
- Ensure actions identified from the infection control audit are completed

Summary of findings

- Take more robust action to ensure patients experiencing mental ill health have the health checks necessary to maintain their wellbeing.

Dr P Oza and Dr R Nam

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist practice manager and a second CQC inspector.

Background to Dr P Oza and Dr R Nam

Dr P Oza and Dr R Nam provide primary medical services to approximately 4121 patients through a personal medical services (PMS) contract. The services are provided from a single branch.

The practice is situated in a former mining community. The practice population live in one of the more deprived areas of the country and the number of children affected by income deprivation is higher than the national average.

The practice team comprises two GP partners providing 20 clinical sessions per week. They are supported by a full time practice nurse and a part time healthcare assistant. The practice employs a part time practice manager and five reception staff.

The practice opens between 8.30am and 6.00pm Monday to Friday. Appointments with a doctor are available between 8.30am and 11.30am every morning and from 3.40pm to 5.40pm every afternoon. The practice offers pre-bookable appointments for extended hours surgeries. These appointments are available on one Wednesday evening and one Saturday morning per month.

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Central Nottinghamshire Clinical Services (CNCS) when the practice is closed.

The practice was inspected in February 2014 using the previous inspection methodology and was found to be compliant in all areas inspected.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to see whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

We carried out an announced inspection of Dr P Oza and Dr R Nam on 07 July 2015. As part of this inspection we received and considered pre-inspection information from the provider.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?

Detailed findings

- 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 organisation to share what they knew, this included NHS England and the clinical commissioning group (CCG). We carried out an announced visit on 7 July 2015. During our inspection we spoke with a range of staff (including two GPs, the practice manager, and the practice nurse and four reception staff). We also spoke with six patients who used the service including two members of the patient participation group (PPG). We observed how people were being cared for. We reviewed seven comments cards where patients shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw evidence of actions identified and discussed following a delayed blood test for a patient to improve communication between clinicians and reception staff.

The practice evidenced thorough recording of significant events dating back to 2003 and demonstrated they had undertaken annual reviews of significant events. We reviewed minutes of meetings where incidents and significant events had been discussed over the last three years. These demonstrated that the practice had managed incidents consistently over time.

Learning and improvement from safety incidents

The practice had a significant event policy in place and a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the records of nine significant events recorded in 2014/2015 and their learning points. We saw records were completed in a comprehensive and timely manner. We saw that learning and actions from significant events were shared with staff. For example, significant events were a standing item on the practice meeting agenda. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw evidence that the practice reviewed all patterns to assure themselves that action taken in response to events had been effective. Records demonstrated that the practice had identified learning from these events.

National patient safety alerts were received electronically by the practice manager and disseminated to the practice nurse. The practice nurse reviewed these and decided on follow-up action required. If the alert was relevant to the practice, the practice nurse printed the information and added it to a folder for staff to read and shared the information with the GPs. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example staff told us about a recent alert related to an outbreak of Middle East Respiratory Syndrome (MERS – a viral respiratory illness) in South Korea. We saw evidence of this alert being disseminated to staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding and domestic violence. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice an appointed dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding but had not completed Level 3 training. They were scheduled to attend Level 3 training later in the year. Staff we spoke with were aware of who the safeguarding lead was and who to speak to if they had a concern.

The practice had a chaperone policy in place though this was not displayed in the waiting area or on the practice website. (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). Staff told us that nursing and reception staff acted as chaperones. We spoke with four members of reception staff who all told us they acted as chaperones. Only two of the four receptionists undertaking chaperoning duties had received training. However, all staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

None of the non-clinical staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks and risk assessments were not in place. (DBS checks identify whether a person has a criminal record or is

on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). This had not been incorporated within the practice's CRB policy dated 25 August 2011. The practice policy further stated that it was not deemed necessary for the health care assistant to have a DBS check. The reason stated for this was that they did not have large amounts of unsupervised contact with children. This did not provide us with sufficient assurance that a DBS check was not necessary for this member of staff in order to protect patients.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

Medicines management

Medicines stored in treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept in a locked room. However, blank prescriptions were not kept within a locked cupboard within this room.

We saw records of clinical meetings that noted the actions taken in response to a review of prescribing data. For example, high cost medicines were reviewed in February 2015 and following a chronic obstructive pulmonary disease (COPD) prescribing review, ten patients' medicines were changed in line with advice from the CCG prescribing adviser. (COPD is the name for a collection of lung diseases)

There was a system in place for the management of high risk medicines which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy in most areas. Patients told us they found the practice clean and had no concerns about cleanliness or infection control.

However, we found the practice had not taken reasonable steps to protect staff and patients from the risks of health care associated infections. For example, the infection control policy and supporting procedures were not comprehensive and sufficiently detailed for staff to plan and implement measures to control infection. We found cleaning guidelines were in place but no schedules were kept detailing the frequency of cleaning and confirmation this had been completed by staff. The practice did not have a system in place for ensuring that curtains in treatment rooms were regularly checked, cleaned or changed every six months.

Staff told us the cleaner attended twice weekly and carried out cleaning tasks for four hours a day which they felt was felt sufficient. There were no arrangements in place to ensure the practice was cleaned when the cleaner was not at work for example through sickness or annual leave. The practice could not provide us with any assurance about how they ensured the premises were clean and hygienic and patients during these times.

The practice had a nurse as the lead for infection control and they maintained the infection control information within the practice. We saw evidence that other practice staff had received infection control training. The practice had completed an infection control audit in February 2015. We saw that some of the required improvement actions had been completed although others had not. For example there was no nappy disposal bin within the patient toilet in spite of the audit identifying this was needed.

Inadequate

Are services safe?

The practice manager told us the practice had no policy or risk assessment in place for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings); therefore the possible risks of infection to staff and patients had not been assessed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms and toilets. There was a good supply of personal protective equipment in the form of disposable gloves and aprons in clinical areas for staff to use to minimise the risk of the spread of infection.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable appliance testing for equipment had been completed. We saw evidence of calibration of relevant equipment, for example blood pressure measuring devices.

However, we found that the practice did not have a system in place to check the expiry dates of equipment and medical consumables. For example we found a large amount of out of date medical consumables including dressings, gauze, syringes and surgical forceps. These had not been disposed of and could be used on patients. The practice nurse was aware these items were out of date and told us she deemed them safe for use as they were unopened. We were not assured by this as the nurse had not risk assessed the safety of using out of date equipment in line with the manufacturer's guidance.

Staffing and recruitment

The practice was unable to demonstrate that effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. Only one member of staff had been appointed since we registered this practice. We looked at their records and there was no evidence of a criminal records check completed through the Disclosure and Barring Service (DBS), no satisfactory evidence of conduct in their previous employment with vulnerable children or adults and no evidence of their qualifications or ID.

Further we found DBS checks had not been requested for the healthcare assistant or for non-clinical staff undertaking chaperoning duties. Additionally, risk assessments had not been carried out on staff that had been employed before the practice was registered with the Care Quality Commission to confirm that the practice were satisfied that they did not need to seek further assurance of staff suitability to work at the practice.

The practice did not have a robust system in place to check the professional registration of clinical staff. The practice manager told us that clinical staff took responsibility for this but she told us there was no system in place to enable her to have an overview ensuring staff remained registered and authorised to practice.

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. GPs we spoke with told us in the event of staff absences for the clinical staff they could liaise with other practices for support. For example a nurse from a neighbouring practice provided cover when the permanent nurse was off sick a number of years ago.

As a small practice, one staff member was allowed leave at any given time and reception staff were flexible to do additional hours to cover holidays and sickness if needed. We however noted that no cover arrangements were in place for when the practice manager was on leave. The practice manager told us their annual leave was arranged around quiet times and limited to a week to minimise risk.

The practice did not use locums to provide cover when a GP was on leave and two patients commented that this made it difficult to get appointments during these times. No cover was provided for the practice nurse during routine leave meaning vaccinations and immunisations would wait until their return.

Monitoring safety and responding to risk

The practice did not have robust 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, dealing with emergencies and equipment. The practice had a health and safety policy but this was not sufficiently detailed to guide staff in their roles and address risks. There were a number of areas where the systems to identify, assess and mitigate risks to patients, staff and others using the practice were not

robust. The absence of risk assessment for key areas was a concern as practice staff were unable to assure us that the way they worked did not present risks to patients, staff and visitors using the practice.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being, domestic violence and injuries to children. One of the GP partners told us they accessed information and advice from the paediatrician in respect of acutely unwell children where appropriate or recommended hospital attendance.

The practice identified patients who had attended and/or were at high risk of hospital admissions and or attending accident and emergency. Records reviewed showed the needs of these patients were discussed at a multi-disciplinary meeting (PRISM) comprising of health and social care staff such as specialist nurses, social workers and an occupational therapist.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed all staff had received recent training in basic life support. Emergency equipment such as an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm) and a nebuliser to assist someone with difficulty in breathing) were available; and staff knew the location of this equipment.

However the practice did not have oxygen in place or a risk assessment in place to demonstrate how the practice would respond in an emergency should this be required. The National Resuscitation Council has the view that 'Current resuscitation guidelines emphasise the use of oxygen, and this should be available whenever possible.' Oxygen is considered essential in dealing with certain medical emergencies. One of the GP partners felt that oxygen was not required as the risk of needing it was minimal. The partner also raised concerns about the additional training need for staff and cost in respect of having oxygen on the premises. Mouthpieces for emergency equipment for both adults and children were out of date and some of these were not sealed therefore we could not be assured they were sterile and safe for use.

The practice had medicines available to treat a range of medical emergencies such as anaphylaxis (allergic reaction) and hypoglycaemia (very low blood glucose). Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However this had not been reviewed since September 2012. Mitigating actions were recorded to reduce and manage the risks relating to disruption of services, adverse weather and unplanned staff absence. The plan contained relevant contact details for staff to refer to. We found the plan highlighted that the immunisation of babies and maternity services cannot be suspended during any disruption for a period of more than 48hours. However, the practice nurse confirmed when they were on leave their role was not covered and as a result some baby immunisations were delayed. Therefore we were not assured that the practice was following its own policy.

The practice had carried out a fire risk assessment in January 2014 but this did not include actions required to maintain fire safety. Staff told us they tested the fire alarm monthly and the system was serviced annually including the intruder alarm. Fire training and a fire drill had been booked for October 2015. Records showed that staff received fire training in October 2012.

We saw exposed wires in a socket within the reception area. The practice manager told us that arrangements had been made for this to be covered. There was no warning notice in place.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with 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 practice nurse used this information to identify patients with specific conditions or needs and discussed the required action with the clinical team. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with chronic obstructive pulmonary disease (COPD) were having regular health checks and were being referred for community matron input and further support provided at home. (COPD is the name for a collection of lung diseases). The most recently published data showed that 100% of patients with COPD had received a review by a healthcare professional in the last 12 months. This was 13.7% above the CCG average.

The GPs told us they led in specialist clinical areas. For example one of the GP partners was the lead for diabetes and chaired a local group in relation to this. The practice nurse and health care assistant supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up by their named GP to ensure that all their needs continued to be met. The practice manager had identified the 2% of patients most at risk of a hospital admission and care plans were in place for these patients.

The practice has ways of identifying patients who needed additional support. The practice kept registers of patients with a learning disability, dementia and mental health conditions.

Management, monitoring and improving outcomes for people

The practice showed us six clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example the anti-depressant prescribing in primary care audit was initially completed in November 2013 in response to NICE and medicines and healthcare products regulatory agency (MHRA) recommendations. The initial audit had demonstrated that the practice was failing to meet required recommendations. A re-audit was carried out following this to ensure that there had been improvement in anti-depressant prescribing. The re-audit demonstrated clear improvements with improved outcomes for patients which included reviews of patients at risk of self-harm on a regular basis and changes to medication.

Other audits related to prevention of cardiovascular disease in patients with high blood pressure and consideration of gastric protection prescribing on patients on both taking specific medications.

The audits we saw were based on NICE guidance. We also saw evidence of a clinical audit undertaken in conjunction with the CCG pharmacist as part of the prescribing incentive scheme.

The practice used information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

This practice was not an outlier for any QOF clinical targets. Published data showed it achieved 97.5% of the available points for clinical results in 2013/2014 which was 7.2% above the CCG average and 5.2% above the England average. The practice provided us with data which indicated it had achieved 92.4% of available points in 2014/2015.

Requires improvement

Are services effective?

(for example, treatment is effective)

Published data showed that:

- Performance for diabetes related indicators was better than the CCG and national average. The practice achieved 98.3% of the available points which was 8.6% above the CCG average and 3.2% above the England average
- The practice achieved 100% of available points for COPD indicators which was 4.5% above the CCG average and 4.8% above the England average
- Performance for mental health related indicators showed that the practice had achieved 100% of the available points which was 12.5% above the CCG average and 9.6% above the England average. However, this data showed that the practice had an exception rate of 34.4% for mental health indicators which was significantly greater than the CCG average of 18% and the national average of 13.3%. The practice had 37 patients on its mental health register at the time of the inspection. The practice had a clinical prevalence rate for mental health which was slightly higher than the CCG average and similar to the national average.

The practice provided us with data for their performance in 2014/2015 which indicated that they had achieved maximum scores in some areas including dementia, cancer, epilepsy and rheumatoid arthritis. However, there were some areas which required improvements including diabetes where the practice had achieved 87.3% of the available points which was lower than the previous year. The practice had also reported an achievement of 68% for mental health related indicators which as lower than the previous year.

The practice's prescribing rates for hypnotics and antibacterial prescription items were above the national average. For example the average daily quantity of hypnotics for specific therapeutic group age-sex related prescribing unit was 0.64 compared with a national rate of 0.28. The practice was aware of this and had worked with their prescribing advisor to try to address this. The practice told the high rate of prescribing was due in part to a high prevalence historically and a high incidence of drug use locally. The practice was situated in an area with levels of deprivation above the national average and slightly above the local (CCG) average. The practice told us that their clinical prevalence for depression was above the local average. Published data for 2013/14 indicated that the clinical prevalence rate for the practice was 11.89% which was 6.66% above the CCG average and 6.72% above the national average. The clinical prevalence rate for mental health was similar to the local and national averages, being 0.2% above the local average and 0.04% above the national average.

The practice had an overspend in relation to prescribing and had worked with the CCG pharmacist to bring this down. The practice had undertaken a review of high cost medication in February 2015 and we saw documented evidence of this. We saw evidence of patients being prescribed alternative drugs to address overspend. The practice had an adherence rate to the CCG preferred prescribing list of 85.05%.

The practice had a palliative care register and had regularly multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had identified 2% of patients at high risk of admission to hospital and had care plans in place for these patients. These care plans were reviewed on a six monthly basis.

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 with one having an additional qualification in obstetrics and gynaecology, and one with an additional qualification in child health. The senior GP partner had an interest in diabetes and the other partner had an interest in sports medicine.

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

Staff we spoke with told us they had received annual appraisals that identified their learning needs. We saw evidence of completed appraisals for non-clinical staff. These were detailed and clearly outlined objectives for staff. Copies of appraisal documentation seen for clinical staff did not assure us that appraisals for these staff were robust. The practice provided us with copies of appraisal planning documents but these were not completed in

detail for all clinical staff and did not always identify clear objectives. One of the GP partners was a GP tutor with a local university so the practice regularly hosted medical students although there was not one at the practice at the time of the inspection.

We saw evidence that the practice nurse was trained appropriately to fulfil their duties. For example, on administration of vaccines, cervical cytology. The practice did not have a system in place to monitor and confirm professional training and appraisals for clinical staff took place, although we saw evidence of the completion of training the practice considered to be mandatory. The practice manager told us that clinical staff kept a record of their own training and usually retained the certificates for this. The practice manager informed us that appraisals for clinical staff were not held centrally.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support people with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. GPs read all incoming information and this was summarised and read coded by the practice nurse. The GP who saw these documents and results was responsible for recording the action required and follow-up appointments were arranged by the practice nurse.

Emergency hospital admission rates for the practice were slightly above the CCG average. For example the practice rate per 1000 population for non-elective emergency admissions was 105.6 compared to a CCG rate of 101.4. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital and review these patients within three days. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held a range of multidisciplinary team meetings at least monthly to discuss the needs of complex patients, for example those with end of life care needs or those at risk of hospital admission. These meetings were attended by occupational therapist, district nurses, community matron, palliative care nurses and decisions about care planning were documented. Staff felt this system worked well.

Information sharing

The practice used several electronic systems to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used an electronic system between the practice and the local hospital/labs for blood tests, x-rays requests and results. Staff told us that the system helped to reduce errors, for example from hand written forms as the information was printed directly from the system. The system also flagged if the same test had recently been requested and alerted the hospital that the bloods or requests were on their way.

Consent to care and treatment

The practice did not have policies in place regarding the Mental Capacity Act 2005, the assessment of Gillick competency of children and young adults or for some specific scenarios where capacity to make decisions was an issue for a patient. This included do not attempt resuscitation. (A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options).

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

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 discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice

Requires improvement

Are services effective?

(for example, treatment is effective)

obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. However, the practice had no general consent policy related to other treatments.

Health promotion and prevention

New patients who registered with the practice completed a questionnaire which detailed any health conditions or issues. Patients were invited for a check-up with the nursing team and referred to the GP as required.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 122% of patients in this age group took up the offer of the health check. This was based on completion of 148 health checks against a target of 121 set by the CCG.

The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 98.2% of patients over the age of 16 and 68.9% of these patients were offered support or treatment in the last 24 months. 90% of these patients had been offered smoking advice or referral to specialist.

Published data showed that the practice's performance for the cervical screening programme was 82.6%, which was 0.7% above the national average and 2.7% below the CCG average. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice nurse had responsibility for following up patients who did not attend. The practice nurse asked patients to complete a disclaimer form if they did not want cervical screening. An audit undertaken showed only one out of 229 cervical samples was found to be inadequate.

The practice told us they encouraged their patients to attend national screening programmes for bowel cancer and breast cancer screening but were aware that patients did not always attend. Data showed the practice achieved a 53% uptake in bowel screening which was below the CCG average of 57%. With regard to breast screening the practice achieved a 67% uptake which was significantly below the CCG average of 81%. Data showed the practice was in the bottom percentile for screening uptake compared with other CCG practices up to September 2014.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above the CCG average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 73.1%, at risk groups 54.2% and pregnant women was 63.4%

Childhood immunisation rates for the vaccinations given to under twos ranged from 87.5% to 100% and five year olds from 75% to 100%. These were comparable to CCG averages.

Requires improvement

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 and a survey of patients undertaken with the practice's 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 also reviewed comments on the NHS choices website regarding the practice.

The evidence from all these sources showed most patients were satisfied with how they were treated and this was with compassion, dignity and respect.

For example, the national patient survey included responses collected during January to March 2014 and July to September 2014. There were 371 survey forms sent out of which 109 responses were received. This represented a 29% completion rate. The majority of the 109 respondents rated the practice as good or very good for most of its satisfaction scores on consultations with nurses and doctors. For example:

- 98% had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 98% and national average of 97%;
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%;

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and professional. They said staff treated them with dignity and respect. Two of the seven patients made comments that were less positive in respect of reduced availability of appointment when one of the GPs was on leave. We also spoke with four patients on the day of our inspection. They were mostly satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that due to the layout of the building, confidentiality was difficult to maintain. The waiting room was open and conversations between patients and staff could be overheard. However, we saw that staff made efforts to minimise any risk by having music playing in the reception area and speaking quietly as required. Reception staff told us that if a patient wished to speak with them confidentially, they would take them into a separate room. There was no information in the waiting room to inform patients about this. However, none of the patients spoken with during our inspection expressed any concerns about their privacy or confidentiality.

Care planning and involvement in decisions about care and treatment

The four patients we spoke with told us their health issues were discussed with them and three of them felt involved in decision making about the care and treatment they received. One made less positive comments related to consultations with GPs.

Most of the patients 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.

The patient survey information from January 2015 however showed there was a significant variation in respect of the results about patient involvement for doctors and nurses. For example;

- 97% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 93% and national average of 90% and
- 94% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

Requires improvement

Are services caring?

However, the satisfaction rates for GPs were below the CCG and national averages. For example;

- 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86% and
- 69% said the last GP they saw was good at involving them in decisions about their care which was below the CCG average of 79% and national average of 81%.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, long term conditions or those requiring end of life care. Annual health reviews and individual care plans had been developed for these patients. For example, the practice had identified 2% of patients at high risk of hospital admission and had care plans in place for these patients. Patients at risk of hospital admission had named GPs who updated their care plans every six months and who contacted them following discharge from a hospital admission.

The practice manager told us that English was the first language of the majority of patients registered with the practice. 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 patients that this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed the same variation between patients' experience of emotional support from nurses and GPs For example:

- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%;
- 96% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 94% and national average of 91%;
- 95% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 94% and national average of 92%.

However respondents did not rate the GPs as well in these areas;

- 73% said the last GP they spoke to was good at treating them with care and concern which was below the CCG average of 83% and national average of 85%.
- 77% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%;
- 77% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.

Leaflets and posters in the patient waiting area told people how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was a carer. The practice sought to identify carers through consultations with staff and via self-declaration. The practice had carers' information within their new patient welcome pack and information displayed in the waiting area. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they cared for. For example carers were invited for annual flu vaccinations.

The practice nurse was alerted when a patient had been bereaved. They told us they would make contact with the patient after a few weeks if the patient had not been in contact with the practice before then.

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 patients' needs and had systems in place to maintain the level of service provided. The practice provided a range of services in house, for example, phlebotomy (taking blood), cervical screening, child immunisation and travel vaccinations. Management of long term conditions included INR star monitoring (testing used to monitor the effects of warfarin) and rheumatology monitoring. This meant that patients registered with the practice did not have to travel to the hospital to receive these services.

The practice provided a range of clinics for the management of long term conditions including asthma, chronic obstructive pulmonary disease (COPD) and diabetes. Appointments were available when patients required them and the nurse based the appointment length on the needs of the individual patient.

The practice offered minor surgery and family planning and a midwife attended the clinic on a weekly basis to run antenatal clinics for patients.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. Records reviewed showed the practice was engaged in collaborative working with other practices in the locality to improve patient access. For example practice patients could access walk community clinics at a local practice on Wednesday evenings and Saturday mornings. Additionally the practice held monthly risk stratification meetings to help prevent hospital admissions and held a falls prevention register.

We noted that some service provision was limited when key staff such as the practice nurse and GP partner went on leave as their roles were not covered. The practice manager confirmed the practice did not use locum cover for annual leave for clinical staff.

Data showed the practice had high rates of non-elective admissions, outpatient first attendances and A&E attendances compared to similar practices within the locality and similar values were achieved for patients accessing the walk in centres. For example:

- The practice rate per 1,000 patients for non-elective emergency admissions was 105.6 compared to a CCG average rate of 101.4
- The practice rate per 1,000 patients for outpatient first attendances was 211.4 compared to a CCG average rate of 182.6
- The practice rate per 1,000 patients for A&E attendances was 320.2 compared with a CCG average rate of 300.8

We spoke two members of the patient participation group (PPG) about the interaction between the practice and PPG. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The practice had implemented suggestions for improvements and made changes to the way in which it delivered services. For example the practice had introduced more pre-bookable appointment slots for GPs and the practice nurse and we saw evidence of the availability of these slots.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of patients in the planning of its services. For example, people with learning disability and people whose first language was not English. People with learning disabilities were offered longer appointments of about 30 minutes with the practice nurse. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The practice covered the first and second floors of the building, with all of the services for patients being provided on the ground floor to facilitate access. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. The practice and PPG had identified that seating in the waiting area was too low for patients with back problems and plans were in place to raise seating.

There was no hearing assistance loop available for patients, we spoke with one patient who was deafened and confirmed they could still communicate with staff.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed this training in the last 12 months and training records confirmed this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us they would accept an alternative address for patients who were homeless wanting to register with the service.

We saw evidence that issues had been raised about access for patients using a wheelchair. The outer door of the practice had assisted opening, but the inner door did not meaning that people using wheelchairs could become stuck between the two doors. The PPG members and staff told us they were aware of this issue and reception staff tried to ensure they checked regularly to ensure this did not happen but a permanent solution had not been agreed.

Access to the service

The practice opened from 8.30am to 6.00pm on weekdays. Appointments with the doctors were from 9.00am to 11.30am including five urgent appointments; as well as from 3.40pm to 5.40pm with four urgent appointments. Appointments with the nurse were available from 9.00am to 11.30am; and 12.30pm to 4.10pm. To help patients who worked, the practice offered extended hours once per month on Saturday mornings and Wednesday evenings. The practice planned to move this to Tuesday evening to avoid a clash with the community clinic.

Comprehensive information was available to patients on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits. Patients could also make appointments on line, via the telephone or in person to ensure they were able to access the practice at times that were convenient to them.

Staff told us a range of appointments were available to patients including pre-bookable routine appointments up to two weeks in advance with a preferred GP and four weeks with the practice nurse and healthcare assistant. Our review of the appointment system showed the next pre-bookable GP appointment was available within a week. Extra appointments were also released on a daily basis depending on demand and patients with urgent concerns could book an appointment on the same day of which we saw happening on the day of the inspection. If patients had urgent concerns and no appointment was available they would receive a call back/telephone consultation from the GPs to address their needs. GPs told us they conducted around six telephone calls backs/ consultation per day.

There were arrangements in place 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. The practice website also provided information on accessing out-of-hours care.

Access to the service and continuity of care was prioritised and we found this was an outstanding feature of the practice. This was corroborated by the high number of consultations available (20 sessions per week). The two full-time doctors conducted six telephone consultations and on average one home visit a day. The practice did not use locums. This was further supported by the data we reviewed from the National Patient Survey published in January 2015. The results showed the practice had performed above the local and national averages in respect of patient satisfaction with access to the system and availability of appointments. For example:

- 80% found it easy to get through to this practice by phone compared to the CCG average of 67% and national average of 73%;
- 88% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 84% and national average of 85%;
- 81% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%;
- 71% of practice respondents felt they didn't normally have to wait too long to be seen compared to the CCG average of 61% and national average of 58%;
- 80% usually wait 15 minutes or less after their appointment time to be seen compared to the CCG and national averages of 65%.

The GPs told us they felt that not using locums and having high rates of consultation afforded increased continuity of care to their patients. This was supported by patient survey data. For example:

- 70% of respondents with a preferred GP usually get to see or speak to that GP compared to the CCG average of 54% and a national average of 60%

The practice offered ten minute appointments with the GPs. Reception staff told us they had booked longer appointments for the GPs when requested by patients but gave an example of an occasion where this was changed back to a single appointment by the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients to understand the complaints procedure was available on the practice website and in the practice waiting room. None of the patients we spoke with had ever needed to make a complaint about the practice, although one patient commented that they wouldn't know how to. Staff spoken with told us they would refer complaints to the practice manager if required.

We looked at four complaints received in 2014/2015 and found that these had been fully investigated and responded to in a timely way. The records we saw assured us that the practice responded positively to complaints and had an open and transparent approach when responding to these. For example, we saw a comprehensive response and learning points to a complaint made about the attitude of a GP.

We saw evidence that the practice reviewed complaints annually to detect themes or trends and lessons learned were discussed as a whole practice team. Formal and informal complaints were a standing item on the agenda at practice meetings. We reviewed minutes of practice meetings which showed that learning points and actions were shared with staff.

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's aims and objectives were included within its statement of purpose which was available on the practice website. Staff had some awareness of the practice aims and objectives.

The practice did not have a formalised business plan or strategy but the practice manager told us that the practice had been focussed on undertaking refurbishment work. The majority of this work has been completed. The practice manager told us they planned to have an additional treatment room which could be used for the visiting midwife or for medical students.

The practice was actively involved in collaborative working with practices within the locality to ensure integrated care was delivered within the community. For example, one of the GPs regularly attended meetings of practices within the locality to discuss issues. The practice nurse also met with other practice nurses in the locality to receive clinical support.

The practice was aware of the challenges it faced, for example deprivation levels affecting older people, vulnerable adults, and people with long term conditions.

Governance arrangements

The practice manager only worked part time at the practice and had limited oversight of some important areas such as clinical appraisals, training and professional registration of clinicians. These records were held by the individuals concerned and this impacted significantly on the oversight and governance of these areas.

The systems in place to enable the leadership team to identify, assess and mitigate against risks to patients, staff and others were not robust and did not provide effective oversight. It was evident that the systems in place were not robust and did not support and enable good governance (for example, oversight of some clinical outcomes, such as those for patients experiencing mental ill health, checks on the dates of medical consumables, infection control, safe recruitment, staffing requirements and cover.

The practice had some policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice We saw evidence that staff had signed to confirm having read policies. However, key ones were absent, for example one on capacity and consent and in other cases the practice was not following its own policies for example the business continuity plan. Some policies, for example those relating to scanning of patient information and hospital reports were overdue for review since March 13 and contained the former practice manager's details. Other policies such as DBS checks and safeguarding needed to be updated to ensure they incorporated the latest guidance and contained sufficient information to guide staff in their roles.

Leadership, openness and transparency

There was a leadership structure in place comprising of two GP partners, a practice nurse and the practice manager who worked part time. We saw from minutes that formal practice meetings were held at least every quarter and ad hoc discussions were held by staff as and when needed. We saw evidence of detailed discussions. For example regarding urine sampling and appointment booking. Clinical meetings were held monthly. Staff told us they were happy to raise any issues with the practice manager and felt an open culture was promoted enabling them to put ideas forward for improvement.

The practice manager was responsible for human resource policies and procedures. Staff we spoke with knew where to find these policies if required.

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

We spoke with two members of the patient participation group (PPG) about the relationship between the group and the practice. The PPG member told us that there were approximately eight members and between three and six members attended regularly. There was also a virtual group who provided input via email. The group met every quarter at the practice. Examples of actions undertaken by the practice in response to patient feedback included changing the appointment system to enable more pre-bookable appointments and enabling advertising of services provided within the practice for patients and externally via a television screen in the waiting area. The PPG had identified the need for the seating in the waiting area to be raised and arrangements for this work to be carried out were underway.

The practice had gathered feedback from staff through staff meetings and discussions. Staff told us they would not

Are services well-led?

Requires improvement

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

hesitate to give feedback and discuss any concerns with the practice manager. Clinical staff reported they had lunchtime catch ups and meetings were arranged at flexible times.

The practice demonstrated it had a robust system for dealing with complaints from patients and implemented learning from these.

Management lead through learning and improvement

Records reviewed showed compliments, complaints, significant events and clinical issues were discussed at staff meetings to improve services delivered to patients and promote learning.

Staff told us they had been supported to undertake relevant training and development to provide additional services to patients. This included spirometry (lung function) testing for the practice nurse and cervical cytology. All of the reception staff told us that they attended protected learning time on a regular basis to update themselves on changes or new practice. This was usually held on a monthly basis on a Wednesday afternoon. The time was used

The practice was a training practice for first, second and fifth year medical students and none were on placement at the time of our inspection.

The GPs also attended bi-monthly meetings with other practices as part of collaborative working and service improvement.

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 17 HSCA (RA) Regulations 2014 Good governance Good governance was not operated as the provider did not have robust systems in place to assess, monitor and mitigate the risks relating to health, safety and welfare of service users. The provider did not have any robust risk assessments in place, for example them provider did not have a risk assessment related to the premises or environment. The provider did not have appropriate policies and procedures in place to support the management of risk to health, safety and welfare of service users. 17 (1) (2) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who used the service were not protected from receiving unsafe treatment from staff that had not been confirmed to be fit and proper to perform their role. The provider had not operated effective recruitment procedures as they had not undertaken checks as detailed in Schedule 3 or undertaken risk assessments where this information was not available. The provider did not have robust procedures for undertaking criminal background checks. For example, no DBS check had been undertaken for the health care assistant or members of reception staff carrying out chaperoning duties. 19 (3) (a) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment was not provided as the provider did not assess the risks to the health and safety of service users receiving care and treatment. For example, the provider did not have oxygen on site for dealing with emergencies and had not assessed the risks associated with this. The provider had not ensured equipment used to provide care or treatment was safe for use as medical consumables were past their expiry date. For example syringes, and wound dressings. The provider did not have adequate arrangements in place for assessing the risk of, and preventing, detecting and controlling the spread of infections. For example, there were no cleaning schedules in place and no cover arrangements for when the cleaner was absent. 12 (2) (a) (b) (e) (h)