The Vineyard 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?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

The Vineyard Surgery provides general medical services to approximately 3700 patients in Richmond, Surrey. It is one of two practices operated by this provider.

We visited the practice on 27 October 2014 and carried out a comprehensive inspection of the services provided.

We rated the practice as 'Requires Improvement' overall; 'Good' in the domains of caring and responsive and 'Requires Improvement' in the domains of safe, effective and well led. We rated the practice as 'Requires Improvement' for all six population groups we looked at including older people, people with long-term conditions, 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).

Our key findings were as follows:

The practice provided a caring and responsive service. There was a good skill mix amongst staff at the practice. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. We saw from our own observations and heard from patients they were treated with dignity and respect. The practice understood the needs of its patients and was responsive to them.

Our key findings were as follows:

- Staff at the practice were aware of the need to report incidents, complaints and safeguarding concerns
- The number of incidents was low but where they had occurred investigations, outcomes and actions were clearly documented
- All patients we spoke with during the inspection told us they felt safe in the care of the doctor and nurses at the practice
- The practice was clean and there was a nominated infection control lead
- The practice scored above the CCG average for the ease of making an appointment

Summary of findings

- Patients we spoke with on the day and who left comment cards felt they were consulted and involved in their care, and were treated with dignity and respect
- Staff were complimentary about the availability to training; and the visibility and access to the partners

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

Importantly, the provider must:

- Put a system in place to disseminate learning from incidents, complaints, safety alerts and significant events to all staff and use such occurrences for risk assessment and quality improvement
- Ensure that recruitment processes are thorough, and include seeking references, proof of identity and, where appropriate, a criminal records check for new staff
- Complete the infection control audit and take action where appropriate
- Review the procedure for actioning test results to ensure they are promptly dealt with
- Provide staff with regular supervision and annual appraisal
- Ensure there is a governance framework to support the delivery of good care

In addition the provider should:

- Advertise to patients that they can request a chaperone if they wish for one
- Keep a log of prescription pad numbers
- Monitor the cleaning contract
- Update the business continuity plan
- Provide all new staff with an induction
- Provide regular team meetings and facilitate all staff attendance where possible
- Have a consistent vision for the practice and a strategy to deliver this
- Monitor medicines to ensure that they remain in date

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses, however they did not have a specific significant event policy or procedure to follow and lessons learnt were not communicated widely enough to support improvement. We found staff recruitment procedures were not as thorough as they needed to be, with gaps in the essential information new staff were required to provide. An infection control audit had been started but not completed. Staff stated they had not received fire safety training, however records provide subsequent to the inspection indicated most staff had received some fire safety training.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. Data showed most patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. However test results were not always actioned promptly. Staff have received training appropriate to their roles and further training needs have been identified and planned. Staff did not receive regular supervision or an annual appraisal.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and worked closely with local providers who provided services to vulnerable people. Patients reported good access to the practice, and little difficulty in making an appointment, albeit not often with their preferred GP, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded to issues raised.

Summary of findings

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice partners each spoke of their vision for the practice but their views did not wholly coincide and there was no clear a strategy to deliver these. Not all staff were fully aware of their responsibilities and they felt there was a lack of cohesiveness. The practice proactively sought feedback from patients and had a patient participation group (PPG). Not all staff had received inductions, none had has supervision or appraisal in the last year, whilst team meetings were not made accessible to all.

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. Nationally reported data showed the practice generally had good outcomes for conditions commonly found amongst older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population and was responsive to their needs by, for example, offering home visits. All patients over the age of 75 had a named GP and the practice was currently contacting each of them every 3 months to review their care needs.

However, improvements are needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall management oversight, all of which can impact on the quality of patient care.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. The practice maintained a register of patients with chronic illnesses and structured annual reviews to check their health and medication needs were being met. For example, all the 18 patients with a chronic obstructive pulmonary disease were invited for a winter review; and all 31 patients with atrial fibrillation had had their medication reviewed and were prescribed anti-coagulants or were exempt from the need for them.

However, improvements are needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall governance framework, all of which can impact on the quality of patient care. However, improvements were needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall governance framework, all of which can impact on the quality of patient care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. Immunisation rates had been low however the practice had taken action to improve this and rates had risen in most cases to above the CCG average for all standard childhood immunisations.

Summary of findings

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. The take up of cervical smears was above the CCG average.

However, improvements are needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall governance framework, all of which can impact on the quality of patient care.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the population group of the working-age people (including those recently retired and students). The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, and flexible.

The practice was proactive in offering online services as well as a range of health promotion and screening which reflects the needs for this age group. For example telephone consultations were available, extended hours offered a wider choice of appointment times and repeat prescriptions were available online. Students returning home for holidays were offered temporary registration. Patients between the ages of 40 and 74 were offered a health check.

However, improvements are needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall governance framework, all of which can impact on the quality of patient care.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities. The practice had carried out annual health checks for all people with learning disabilities, and had an open door policy to users of the nearby homeless persons service.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients with limited capacity. The practice maintained a

Summary of findings

register of patients who were at risk of unplanned hospital admissions. Each patient had a named GP and access to a virtual ward run in conjunction with social services and the community matron.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

However, improvements are needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall governance framework, all of which can impact on the quality of patient care.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people in this population group. It cared for residents from a local residential service, who visited the practice on an individual basis with care staff. Staff were aware of the need for these patients to be seen promptly. The electronic record system would flag up if vulnerable patients were attending for an appointment so that staff were aware of any relevant issues.

However, improvements are needed with regard to staff recruitment and support; monitoring infection control; the processes for dealing with test results and the overall governance framework, all of which can impact on the quality of patient care.

Summary of findings

What people who use the service say

We spoke with 5 five patients during the course of our inspection. We asked to speak with a representative of the Patient Participation Group (PPG) however none were available. We reviewed 43 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service, information published on the NHS Choices website, the results of the practice's most recent patient experience survey and the national patient survey 2014.

The evidence from these sources showed patients were satisfied with some aspects of how they were treated. For example, the practice was rated above the CCG average (81%) for its satisfaction scores on consultations with nurses, achieving a rating of 83%. However, 84% of practice respondents said the GP was good at listening to them and 85% said the GP gave them enough time. Both of these ratings were below the CCG average of 88% and 86% respectively.

At the time of the inspection patients told us they felt the practice offered a service that was supportive, thorough, responsive, understanding and professional. Patients said they were treated with respect, dignity and they felt safe.

Less positive comments centred around difficulties getting an appointment, regular changes in GPs which meant a lack of continuity of care, and in a minority of cases, poor attitude displayed by reception staff. This was reflected in the outcome of the 2014 national patient survey, where the practice achieve a 64% satisfaction rate with the ease of making an appointment, compared to the CCG average of 77%. The practice also scored lowly with regard to the number of patients with a preferred GP who usually got to see or speak to that GP, with a rating of 39% compared to the CCG average of 59%. This was reflected in comments made to us during the inspection. However patients did comment they felt that the service provided had improved since the current provider had taken over.

Areas for improvement

Action the service MUST take to improve

- Put a system in place to disseminate learning from incidents, complaints, safety alerts and significant events to all staff and use such occurrences for risk assessment and quality improvement
- Ensure that recruitment processes are thorough, and include seeking references, proof of identity and, where appropriate, a criminal records check for new staff
- Complete the infection control audit and take action where appropriate
- Ensure test results are actioned promptly
- Provide staff with regular supervision and annual appraisal
- Ensure there is a governance framework to support the delivery of good care

Action the service SHOULD take to improve

- Advertise to patients that they can request a chaperone if they wish for one
- Keep a log of prescription pad numbers
- Monitor the cleaning contract
- Update the business continuity plan
- Provide all new staff with an induction
- Provide regular team meetings and facilitate all staff attendance where possible
- Have a consistent vision for the practice and a strategy to deliver this
- Monitor medicines to ensure that they remain in date

The Vineyard Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a practice manager and an Expert by Experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP and Expert by Experience were granted the same authority to enter The Vineyard Surgery as the CQC inspector.

Background to The Vineyard Surgery

The Vineyard Surgery forms part of a partnership with a sister practice in New Malden. It provides primary medical services through a General Medical Services (GMS) contract to approximately 3700 patients in Richmond, Surrey. The practice serves a population of generally low deprivation and with a higher than (England) average number of working patients. Forty one percent of patients have a long standing health condition, which is below the England average of 53%. The majority of patients registered with the practice are from a British or mixed British background.

The practice team is made up of six partners, of which three male partners work a combination of eight sessions per week at this practice. There are a further six sessions of clinical time provided by two female salaried GP's and three sessions per week by nurse practitioner/prescribers.

There is currently a part time practice nurse who works one full day per week, a part time healthcare assistant four mornings per week and one phlebotomist who works one morning per week. An additional two nurses have recently been recruited.

The management team comprises of a full time assistant practice manager supported by a NHS services manager (one day per week onsite) and a business and operations manager.

The practice is currently a training practice for medical students with plans to extend this to junior doctors in approximately 12-18 months.

Opening hours are between 0800 – 1300, and 1330 - 1830 Monday to Friday. Extended hours operate up to 1930 on Tuesdays. The practice is not open at weekends. Telephone access is available during core hours and the practice has an online appointment and repeat prescription request facility. Home visits are provided for patients who are housebound or are too ill to visit the practice. A number of urgent patients same day slots are made available each day. Under-fives and the elderly are prioritised for same day appointments, either with a GP of with a nurse practitioner.

The practice has out of hours (OOH) arrangements in place with an external provider and patients are advised that they can also call the 111 service for healthcare advice.

The practice also provides a ‘Same day doctor’ service to people not registered with them, on a fee paying private basis.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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

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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with Richmond Clinical Commissioning Group (CCG), NHS England and Healthwatch. We carried out an announced visit on 27 October 2014.

During our visit we spoke with a range of staff including three GPs (two of whom were partners), the assistant practice manager, the practice nurse, nurse practitioner, health care assistant, and reception and administrative staff. We spoke with seven patients who used the service. We asked to speak with representatives of the practice's patient participation group (PPG) but they were not available.

We reviewed 43 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed information that had been provided to us prior to and at the inspection and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, audits and risk assessments, staff records and health information and advice leaflets.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. National patient safety alerts were circulated to staff but there was no cohesive system in place to use them as a basis for risk assessment or quality improvement.

Staff at the practice were aware of the need to report incidents, complaints and safeguarding concerns to maintain safe patient care however they did not have a specific significant event policy or procedure to follow. The number of incidents was low but where they had occurred investigations, outcomes and actions were clearly documented. All patients we spoke with during the inspection told us they felt safe in the care of the doctor and nurses at the practice.

The partners had taken over The Vineyard Surgery within the last year. We reviewed safety records and significant events and these showed that in that time, the partners had managed these consistently.

Learning and improvement from safety incidents

The practice kept records of significant events and these were made available to us for events that had occurred during the last 12 months. Whilst these were discussed at clinical meetings, there was no monitoring to ensure appropriate learning had taken place where necessary or that the findings were disseminated to all relevant staff. We noted there had been a prior significant event relating to incoming patient data which had not been scanned into patient records. We were told the coordination of incoming medical reports was the responsibility of the assistant practice manager to oversee and delegate, however this was not obvious to us at the time of the inspection as some test results had not been actioned for several days.

Staff including receptionists, administrators and nursing staff were aware of the need to raise issues however some were not clear what defined a significant event, for example. Complaints were dealt with by the nurse practitioner and/or the business and operations manager and elevated to the senior partner if necessary. We were unable to ascertain how learning from complaints was shared with staff as there was no formal process in place for doing so, and staff told us they were not informed of the outcome of complaints.

National patient safety alerts were disseminated to practice staff by the deputy practice manager. Clinical staff we spoke with were aware of these but we could not evidence systematic learning from them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Clinical staff had received training to Level 3 in child protection, whilst all other staff had been trained to Level 2. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children. This GP was based at the sister practice. Staff were aware who the lead was. There was a child protection policy and procedure in place however the practice did not, at the time of our inspection, have a safeguarding vulnerable adults policy or procedure. The practice produced and sent a procedure to CQC shortly after our inspection.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients with limited capacity, or severe mental illness or dementia.

A chaperone policy was in place but there was nothing in the waiting room or consulting rooms to advise patients that they could request a chaperon if they wanted one. The GP told us that patients would be asked at each appointment if they wanted someone with them. If nursing staff were not available to act as a chaperone, administrative staff would step in. All staff had been trained, however none of the administrative staff had undergone a criminal records check to help assess their suitability for this role.

Requires improvement

Are services safe?

Patients' individual paper records were managed in a way to help ensure safety. They were kept in an electronic metal filing cabinet, which was only accessible by authorised staff. There was a whistleblowing policy and staff were aware of it. Electronic records were kept on the Vision Online electronic system which is a system that also enables patients, with approved access, to view their own records.

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. One member of staff was responsible for checking and recording refrigerator temperatures. We saw the records indicated the temperatures had been maintained at a suitable level, however we found a gap in the records which coincided with the time this person was on leave. Following our inspection we were provided with evidence that the fridges had been checked during this time period, but there was no formal process to delegate this responsibility if the lead member of staff was absent.

One member of staff was responsible for checking vaccines when they were delivered, to ensure the cold chain was maintained and they were aware of the need to rotate the vaccines within the refrigerator and ensure none of the vaccines were in contact with the sides of the refrigerator. We found, however, that one refrigerator was overstocked. Staff agreed to move some of the contents to their second medicines refrigerator so as to prevent the vaccines being compromised.

Processes were in place to check medicines were within their expiry date and suitable for use. With two exceptions, all the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We found expired salbutamol which was discarded immediately when brought to the attention of practice staff. There was alternative, in date salbutamol available.

We saw the practice had completed audits, including re-auditing, in relation to medicine management targets. They had reviewed prescribing as per the medicines management programme (a national initiative aimed at promoting safe, effective and cost effective prescribing) and this was shared with clinical staff by email as the senior nurse circulated the audit results and described best practice. We saw an example of this in terms of methotrexate prescription regarding both tablet size and numbers. The audit reviewed whether, for example, all patients had attended for monitoring bloods within the specified timeframe; if all doses of methotrexate were prescribed in multiples of 2.5mg tablets, and whether and whether all prescribing was initiated by a hospital specialist and prescribed within licensed indication. In each case the audit had shown that the practice had achieved a 100% success rate. The re-audit had identified that one patient was prescribed 10mg tablets instead of multiples of 2.5mg [the actual dose given was correct however] and clinicians were directed towards the National Patient Safety Agency (NPSA) guidelines which state all doses of methotrexate must be prescribed in multiples of 2.5mg tablets.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered flu vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw up to date copies of both sets of directions, relating to, for example, shingles and roto virus vaccinations, and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Staff were clear that if the refrigerator readings were outside the correct temperature range, vaccines would not be used until they had checked with manufacturer.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. Patients or the pharmacist would bring in a request which would be printed off and made available to the patient within 48 hours if routine. Any acute, non-routine or requests for medicines of concern would be reviewed by a GP first. The local pharmacy collected prescriptions and signed to say they had done so. Prescriptions collected in this way were kept separate from those to be collected by patients so as to avoid confusion and improve security.

Prescription pads were kept in locked cupboard however a log of prescription numbers was not maintained contrary to national guidance (NHS Protect recommends that as a matter of best practice, prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be

recorded. It is also good practice to record the number of the first remaining prescription form in an in-use pad at the end of the working day. This will help to identify any prescriptions lost or stolen overnight).

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw the practice had a cleaning contract in place but that there was no monitoring of this to ensure that the cleaners carried out the work that was required to the standard desired. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who was able to illustrate the various areas she monitored. For example, she ensured the nebuliser was cleaned after each use, as was the spirometer. There was no clear delegation of the lead role however when the lead was away. Disposable instruments were used where needed, to avoid the need for sterilisation. We checked and found that the disposable equipment, such as swabs, forceps and scalpels were all in date. A risk assessment was in place relating to spillages. Staff were aware where the spillage kit was kept and where to find instructions on how to use it.

We were told the lead had carried out an audit before the recent commencement of minor surgery procedures at the practice, however the documentation was not available at the time of the inspection. This was submitted after our inspection and indicated that the practice has started an audit, however it was incomplete. For example, several areas had been identified as requiring attention but no action plan had been drawn up.

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

Hand washing sinks with soap and hand towel dispensers were available in treatment rooms and toilets. Washable chairs were used in the patient waiting room, and disposable curtains used in the treatment rooms.

There was a sharps injury policy on display in every room. Sharps bins were dated and not overfilled. We saw weekly checks were carried out and recorded. A locked clinical waste bin was kept outside the premises and a contract for clinical was disposal was in place. The infection control lead had undergone training on waste management.

The practice had identified that it was possible not all clinical staff had up to date Hepatitis B vaccinations. They were currently looking at this and told us that if necessary, they would arrange for staff to be vaccinated. Staff told us that the practice encouraged them to have flu and Hepatitis B vaccinations.

The practice did not carry out tests for legionella (a germ found in the environment which can contaminate water systems in buildings) as they felt it unnecessary as they did not have a water tank. They had not, however, carried out a risk assessment to determine if there were any 'dead legs' in the system (a pipe leading to an outlet through which water flows but the outlet is unused/rarely used) which potentially could harbour the germ.

Equipment

Staff we spoke with told us they had sufficient 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 equipment maintenance logs and other records that confirmed this. A schedule of testing was in place. We saw, for example, all portable electrical equipment was routinely tested, the fire extinguishers had been serviced in June 2014 and the water cooler (in the patient waiting room) had been serviced in October 2014. The ECG monitor had been tested in February 2014.

The practice has conducted own internal review to identify where action may be needed. This had identified that the practice did not have emergency lighting for example, however a timescale for rectifying this had not been confirmed due to the uncertainty over a possible move to alternative premises. The review also identified that a new switch was required for the vaccines refrigerators and a target date had been set for this to be installed.

Staffing & Recruitment

Staff recruitment records were not kept on site (they were kept at the other practice); however the business manager had provided a detailed audit of those records. This

indicated that the recruitment process was not as thorough as it should be. For example, references had not been sought for two staff who had been employed recently; some staff had not provided proof of identity and several had not had criminal records check carried out. This included a nurse practitioner.

There was a good skill mix amongst staff at the practice. For example the practice had recently recruited two additional nurses, and also had nurse practitioners already in post.

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 they was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. Staff generally covered for each other during holiday periods, and additional GPs could be called upon from the sister practice if necessary. This had meant The Vineyard had been able to reduce its use of locum GPs.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included in a risk assessment, which was up to date. The practice had not carried out any legionella testing as they did not have a water tank and water was provided through a rising main.

An accident spillage kit was kept in reception. Staff told us they knew how to use the spillage kit but that they had not, for example, been shown how to use the fire extinguishers and could not recall having received fire safety training (records provided post the inspection indicated most of the staff had received fire safety training).

The practice had a contract in place for the disposal of confidential waste.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen, a nebuliser and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records confirmed these were checked regularly, with the next scheduled test due in February 2015.

Reception staff told us they would immediately talk to the assistant practice manager if they were concerned about a patient in the waiting room. They also had access to a computerised alert button which they could press to raise the alarm in an emergency if, for example someone collapsed. Staff told us they had not to date had to use this, but they had carried out practice runs which had proved effective as clinical staff came immediately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Whilst most were appropriate we noted the practice had stocked intravenous diazepam rather than rectal diazepam. All the other medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, loss of IT equipment and medical epidemics. The document would benefit from review as it referred to a now obsolete NHS structure.

A fire risk assessment had been undertaken that included actions required to maintain fire safety.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. We saw minutes of practice meetings but could not identify that they were used to disseminate new guidelines.

We discussed the practice's chronic disease registers with the nurse practitioner. We were provided with a detailed breakdown of the number of patients on each register and the action the practice was taking to ensure they were regularly reviewed. For example, 63% of asthmatics had been reviewed this year. Patients were invited to attend a review, and if they were unable to visit the practice a home visit would be carried out.

There were just 12 patients on the practice's dementia register. The nurse practitioner felt that this was not a true reflection of the number of patients with dementia and said it was an area that they needed to focus on going forward. This was supported by the findings of Richmond CCG in their November 2014 report which estimated that 2,075 Richmond residents have dementia. Around 50% of the estimated number of people with dementia had received a formal diagnosis, which was similar to the national average. Locally a goal has been set of achieving a diagnosis rate of 66% by 2015 in line with the national goal.

The practice had 76 patients diagnosed with diabetes. They had a specialist diabetic lead based at their other practice but they did not carry out clinics at the Vineyard. We were told that once the (underway) recruitment for additional practice nurses had been completed, the diabetic lead would be in a position to hold some clinics at Vineyard Surgery. For the time being, if patients required specialist input they would usually visit their local hospital. In most areas of care for diabetic patients the practice performed in line with the national average, and in some cases exceed it. For example, it scored above the national average for the percentage of patients with diabetes with a record of a foot examination and risk classification within the preceding 12 months.

There were arrangements in place to obtain and record a patient's consent, including obtaining consent when treating children. Where patients lacked capacity the practice took account of the Mental Capacity Act 2005 and involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment. Clinical staff understood the Gillick guidelines for gaining consent from children under age 16 (Gillick is a test used by clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The nurse practitioner told us that they had recently employed an apprentice (from a local scheme in Kingston) to assist with an enhanced services project to reduce the number of unplanned hospital admissions. The apprentice was in the process of calling all the patients who had been identified at risk to establish a regular contact and to find out if they were currently well. Feedback from these patients had been positive.

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

Management, monitoring and improving outcomes for people

The practice provided us with two examples of clinical audits they had carried out in relation to medication. The audit cycles had been completed as re-audits had been carried out. The results indicated that the practice has achieved a 100% success rate in the areas assessed. Other than this, the practice concentrated on the audits relating to the Quality and Outcomes framework (QOF). The QOF is a national group of indicators, against which a practice score points according to their level of achievement in the four domains of clinical, organisation, patient experience and additional services.

Are services effective?

(for example, treatment is effective)

Staff from across the practice told us they were frequently asked for information to feed into the QOF performance measures, but that they had no other input into the process other than this, and were not involved in or aware of the outcomes.

The practice had achieved higher than (England) average QOF scores in a number of areas. For example, it has scored 100% with regard to asthma, chronic kidney disease, dementia and epilepsy. However it had achieved below average scores (for England) with regard to, for example, the diagnosis of heart failure and palliative care, scoring 10 out of 27 and three out of six respectively. Prior to the inspection it was noted that the QOF exception rate for this practice was the highest in the CCG area (the QOF includes the concept of 'exception reporting' to ensure that 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) . This was explored at the inspection and we found it could be attributed to the low number of patients involved who also had multiple health needs. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us two clinical audits that had been undertaken in the last year. Both of these were completed audits where the practice was able to demonstrate consistent practice. For example, one audit related to the prescribing of and monitoring of patients taking lithium. The initial audit had highlighted a need for three monthly check ups for patients and the re-audit had indicated this was now taking place.

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. Other training attended by staff included phlebotomy, smoking cessation, data entry and national vocational level 3 qualification training. A good skill mix was noted amongst the staff team however the practice did not utilise all of these skills effectively, as not all skills were shared between the other practice and The Vineyard Surgery, with the other practice benefitting most as, for example, the diabetic nurse specialist held all their clinics as the other practice, whilst none were held at The Vineyard.

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

Since this provider took over the practice in September 2013, staff had not received regular supervision or annual appraisals. Some of the staff team felt unsupported, although they were clear that if they had any specific issues they could raise them with senior staff. We raised the issue of supervision and appraisal with the business manager, the nurse practitioner and one of the GP partners. They generally accepted that appraisals and formal supervision had not been carried out as they had been focussing on getting the practice up and running the way that they wanted it to.

The thoroughness of induction for new clinical staff was mixed. The business and operations manager told us that all new staff had a 3 months probationary period which would be extended if they had concerns. However, some staff said they had received a good induction, including spending time with the GPs and practice nurses, whilst others felt they had been expected to start with very little prior information, no probationary period and no mentoring in place.

Clinical staff told us that they held regular clinical meetings at their other practice, although it was not always possible to attend if they had to cover The Vineyard. If they could not attend they said they were provided with minutes of the meeting. The meetings were used to discuss concerns, specific cases, new enhanced services and share new clinical guidance.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. Those with extended roles, such seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles. Nurses commented that they would welcome being able to meet regularly as a group, so that they could share

concerns, good practice and support each other. They were confident they could approach senior staff if they had any concerns but would welcome more structured performance management.

The health care assistant carried out a range of duties including new patient checks; NHS over 40's checks, blood tests, spirometer tests, ECGs, Removal of stitches and wound management, and blood pressure and urine checks.

Working with colleagues and other services

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. Patients with complex needs at risk of admission to hospital were referred to a local CCG network based 'Virtual Ward' bringing together acute, community and social care professionals to work as one team. The Virtual Ward enabled this multi professional team of clinicians to care for patients in their own home.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. We saw that any member of the administrative team could review and action this information, with no-one taking a lead role and no monitoring system in place to ensure that all tests and letters had been appropriately actioned. This was despite a significant event that had found that some incoming data had not been scanned into patients records and brought to the attention of the GPs, but had been discarded instead (fortunately this information had been retrieved before it was destroyed and actioned appropriately). We checked the tray of post and found the majority of correspondence was dated for the current day, but there was also some dated 22 and 23 October and a GP still had to look at and action them. We also found that staff had still to action results that the doctors had seen from the 21 October.

Feedback from the out of hours service was reviewed the following morning and followed up where necessary. Staff used a specific reporting form for their palliative care/end of life patients so that the out of hours provider was fully briefed.

The practice had a good working relationship with other professionals, particularly the community matron. They worked with other service providers to meet people's needs and manage complex cases. For example, they had established a productive relationship with a local homeless persons project, and as a result project users had confidence in using services provided by the practice. The GPs stated that they were willing to work in a multidisciplinary care setting, but had found this was somewhat disjointed across the area as there were multiple providers who covered a wide range of services. They were in the process, however, of setting up a clinical alliance of practices across the CCG area.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made use of the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). The practice used the electronic Summary Care Record system to assist clinicians treating their patients in an emergency (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The out of hours provider informed the practice each morning which patients had been seen, and sent them a report. The practice would then follow up where necessary with the patient. A specific form was used if the local hospice or palliative care team were involved.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system – Vision One, was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

There were arrangements in place to obtain and record a patient's consent, including when obtaining consent when treating children. For example, we saw completed consent forms for patients who had come to the practice for a flu

Are services effective?

(for example, treatment is effective)

jab. Where patients lacked capacity the practice involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment. Clinical staff understood the Gillick guidelines for gaining consent from children under age 16 and where it had been deemed appropriate that the child could consent this was documented. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures patients were asked to sign a consent form.

The practice had an alert system to flag up if patients with, for example, mental illness or dementia, came into the surgery. Information was held relating to carers and next of kin, with details regarding their capacity to consent. Similar information was held on file for child minders who might bring in the children they were caring for.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. 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. The practice had six patients with a learning disability on its register. Five of the six had undergone a review using the Cardiff Protocol (a protocol used to provide health checks to people with learning disabilities) whilst the sixth had objected to this and had consented to a general health review instead.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40-74. These were carried out by the healthcare assistant. Practice data showed that of 1235 eligible patients, 246 had taken up the offer of the health check. The practice told us that reminder letters were sent to those who had not taken advantage of the offer.

The practice had systems in place to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months.

Staff at the practice had undergone training in smoking cessation however the availability of advice was not clearly advertised to patients. We discussed this with the practice who told us that as patient numbers were low, it was not effective to run specific smoking cessation clinics. As an alternative, patients were offered advice on a one to one basis. We were unable to determine the success rate of this approach.

The practice's performance for cervical smear uptake was 86% which was better than the CCG of 71%. There was a policy to send reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for almost all childhood immunisations was below average for the CCG. The practice told us they were trying to address this and if parents did not attend after being sent an initial letter, this was followed up with a reminder. As a result, for the first three quarters of 2014, the vaccination rate had risen to over 91%, which for the majority of vaccinations surpassed the previous year's CCG average.

Patients were given information to help them manage their care. The availability of information in the practice waiting room was limited, however staff would print out information leaflets for patients when requested.

There were 174 patients aged over 75 registered with the practice. One of the GP partner's told us that currently they were reviewing these patients every three months because they were still a relatively new provider and wished to gain a full picture of their patient groups. Each of the over 75 year old patients had a named GP.

All 31 patients on the atrial fibrillation register had had their medication reviewed and where appropriate been prescribed anti-coagulants. There were 18 patients on the COPD (chronic obstructive pulmonary disease) register. They were invited for a winter review and flu jab.

The practice had 18 identified patients with a chronic obstructive pulmonary disease (COPD). All of these patients were invited to attend the surgery for a winter review.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, NHS Choices and a survey of patients undertaken by the practice in September 2013, and repeated in March 2014. The evidence from these sources showed patients were satisfied with some aspects of how they were treated. For example, the practice was rated above the CCG average (81%) for its satisfaction scores on consultations with nurses, achieving a rating of 83%. However, 84% of practice respondents said the GP was good at listening to them and 85% said the GP gave them enough time. Both of these ratings were below the CCG average of 88% and 86% respectively.

The practice's own patient survey, conducted in September 2013, was completed by 51 patients, who were able to respond enabled to reply electronically or by completing a paper questionnaire. The survey raised some issues, for example regarding receptionist behaviour, and was repeated in March 2014. At the time of the inspection, although requested, the practice was unable to tell us how many patients had replied to the second survey. Subsequent to the inspection, figures supplied by the practice indicated the service had improved in all areas assessed, and they had responded to negative feedback by providing customer care training to receptionists, implementing a text reminder service, providing an information slip to patients telling them how to obtain test results and ensuring patients were informed if a GP was running late.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 43 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a service that was supportive, thorough, responsive, understanding and professional. Patients said they were treated with respect, dignity and they felt safe.

Fifteen comment cards were less positive. Patients complained of the difficulty in making appointments and, in a minority of cases, patients commented on a poor attitude displayed by reception staff. It should be noted that the 15 who made negative comments also gave some positive feedback. We also spoke with 5 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. They felt that the service provided had improved since the current provider had taken over.

We observed that consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Chaperones were available, although this was not advertised in the waiting room.

The waiting room for patients was small and unavoidably provided little privacy for patients when talking with receptionists. Staff told us that they would offer to talk to a patient in a private room if they wished, and a list of patients who preferred not to verbally express their reason for wishing to see a doctor was kept at reception. We observed staff speaking with patients, and saw they were very polite and helpful on the phone and at reception.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager, however they were confident that all patients would be treated the same.

Staff were sensitive to people whose circumstances made them vulnerable. For example, the practice liaised with a local homeless project, and took on unregistered patients. They also looked after patients with severe mental illness, and ensured they were seen promptly.

Care planning and involvement in decisions about care and treatment

The national patient survey 2014 information we reviewed showed patients responded less than positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 64% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. Both these results were below the CCG average of 75% and 83%.

Patients we spoke to on the day of our inspection however 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

Are services caring?

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 predominantly positive and aligned with these views. Patients generally felt the practice had improved since the new providers took over.

We asked if the practice had a translation service for patients who did not have English as a first language. Initially staff were not sure if they did provide that service, but were later able to provide an information leaflet downloaded from the internet which outlined the translation service provided by the local authority, which the practice had not had cause to use to date. The practice's website did provide a translation facility.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice. They told us that, for example, they were pleased with aftercare support provided post surgery; and had found the doctor comforting when discussing personal health issues. The patients we spoke to on the day of our inspection and the comment cards we received highlighted staff responded compassionately when they needed help and provided support when required.

Limited information in the waiting room signposted people to a number of support groups and organisations. For example there were details of a local specialist day service for people with dementia; and a leaflet showing people how to get help for anxiety, stress and depression from the local Wellbeing Service.

Patients who had suffered bereavement told us the GPs had been very supportive and had, for example, visited them at home and been in touch whilst their family member was in hospital. They had found this a humane, personal and much appreciated approach.

Patients told us they were happy with referrals made to other services when required, and found the practice proactive in this respect. We received one negative response from a patient who told us they had received very little diabetic follow up as they had not seen the diabetic nurse for over two years, however no other negative comments re diabetic care were received.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example, the practice had an open door policy for people with no permanent address and worked closely with a local homeless project. Patients with a learning disability were given extra time and staff went through information several times with them to ease their understanding. Patients with an urgent need to see a GP were usually accommodated, with priority given to babies.

The practice had received negative feedback with regard to continuity of care, however most of this feedback related to the previous providers. Patients fed back to us that this had improved with the new provider, albeit there was often a wait to see a GP of choice. Home visits were made to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example they had implement a text reminder service; the reception team informed patients at check in if the clinician was running late and patients were now provided with an information slip explaining how to obtain laboratory results.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example the practice provided a service to residents from a care home for people with serious mental illness. They had a good working relationship with the local mental health trust. The practice had a palliative care register and worked closely with community matron, district nurses and health visitors.

There were six patients with a learning disability on the practice's list. We were told all received an annual review using the Cardiff protocol. One of the nurse practitioner's had been trained to use this methodology.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services and recognised people whose circumstances may make them vulnerable. For example it worked with a local care home for people with severe mental illness and ensured these patients and their carers were seen promptly.

The practice had access to online and telephone translation services and their website offered a translation facility.

The premises and services had been partially adapted to meet the needs of people with disabilities. Patients who used a mobility scooter were directed to alternative services as the building could not be adapted to accommodate them. To date this had only affected one patient who was referred to an alternative practice equi-distant from their home.

Access to the service

Appointments were available from 0800 – 1300, and 1330 - 1830 Monday to Friday. Extended hours operated on Tuesdays between 0730-0800 and 1830-19h30. The practice was not open at weekends. Telephone access was available during core hours and the practice had an online appointment and repeat prescription request facility. A number of urgent patients same day slots were made available each day. Under-fives and the elderly were prioritised for same day appointments, either with a GP or with a nurse practitioner.

Pre-bookable appointments were available, up to 10 days in advance, and patients could also call at 08:00 or 13:00 to get an appointment the same day. Four emergency appointments were held back each day. Telephone consultations were available, usually between 12:00 and 14:00. Home visits could be arranged with reception staff, and the GP confirmed with the patient they still required a home visit prior to leaving the practice to carry out their visit.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone

Are services responsive to people's needs?

(for example, to feedback?)

number they should ring depending on the circumstances. The practice has out of hours (OOH) arrangements in place with an external provider and patients are advised that they can also call the 111 service for healthcare advice.

Patients had mixed views of the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. In the 2014 national patient survey 85% of respondents said it was easy to get through to the practice, which was above the CCG average of 79%. However, the practice was rated as amongst the worst in the CCG area for the experience of making an appointment. Sixty four percent described it as good compared to the CCG average of 77%, and this corresponded to the negative feedback we received about the practice. Patients were also unhappy that they could often not get to see the GP of their choice, which they felt meant a lack of continuity of care. Just 39% of patients with a preferred GP said that they usually got to see that GP compared to a CCG average of 59%. The practice told us that they had started to address the concerns expressed by patients with regard to lack of continuity. They had employed a core number of salaried GPs to reduce the use of locum GPs.

Access for people with serious mobility problems and who required a mobility scooter was not possible due to the layout of the building, however practice informed us they had had to turn away just one potential patient because of this. The waiting and consultation rooms were on the ground floor. The waiting room was small, with very limited space for pushchairs for example, however there was nothing the practice could do to improve this. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Demographically, the population of the local area was predominantly (65%) white British however the practice could cater for different languages through translation services.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The was a designated responsible person who handled all complaints in the practice. Complaints were logged by the practice's business manager and dealt with initially by the business manager or the nurse practitioner. Whilst we were told that learning from complaints was disseminated to staff via team meetings and email, staff commented that they were not made aware of the outcome of complaints.

We saw that a leaflet was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at all the complaints received in the last twelve months and found these had been satisfactorily handled and dealt with in a timely way. We discussed with the practice comments made on NHS Choices. Six comments that had been left since the new partners took over the practice. Three of the comments were wholly positive, one was both positive and negative whilst two contained complaints. The practice had responded to two of the comments however we saw that in one instance they had responded by saying that as the complaint had not been made directly to the practice in line with their complaints procedure it was not possible to investigate this matter. The business manager accepted that this response could have been more receptive and the comments should have been followed up.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients and this was consistently expressed by all the staff team. For example, staff talked of developing the practice, possibly in alternative premises so they could expand, and provide a welcoming and accessible service, utilising the specific skills amongst the staff team. There was a lack, however, of a strategic overview for the whole partnership. At the time of this inspection The Vineyard Surgery benefitted from being part of larger partnership, but had neither developed its own identity nor become an equitable partner to the partner practice with regard to resources and specialist staff. There had been discussion regarding practice development planning however this was in its early stages and not yet documented.

Governance Arrangements

Staff were committed, experienced enthusiastic and capable but many were new to this provider and, as most worked over both practice sites, had not established where they fitted in or what the extent of their roles were. The lack of management oversight was evident, and the staff were not working as a cohesive team.

The practice had a number of policies and procedures in place to govern activity and these were available both as hard copy and electronically. We looked at a number of these policies, including chaperoning, child protection, whistleblowing, data management and health and safety. All had been reviewed in 2013, with a future review date set for 2015.

The practice held a monthly clinical meeting, however these meetings had only recently commenced at the Vineyard and only two sets of minutes were available. The meetings at the sister surgery were well established but not all clinical staff were able to attend either set of meetings. Several staff commented that they thought a regular all-team meeting would be beneficial. We looked at meetings minutes. There was evidence of discussion about significant event analysis (SEA) and QOF.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We were told they also used complaints as a quality improvement tool however staff were unable to provide us with examples of where improvements had been made to the services as a result of this.

There was a reliance on sharing information via email. There was no system in place to ensure that staff either received the emails or acted on them. For example, some staff were unaware of the CQC inspection until the (working) day before it took place, even though the practice had been informed some two weeks earlier. The QOF data for this practice showed it was performing above both the CCG and England average in most areas, with an overall score of 95.8%. We found the QOF exception rate for this practice was the highest in the CCG area, however following discussion with the GP it was evident that this was because of relatively low numbers of patients and a high percentage of those who had co-morbidity.

The practice had arrangements for identifying and recording risks. The business manager showed us their risk assessment which addressed a range of potential issues, such as fire emergency lighting and the protection of refrigerator power switches. The practice had processes in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, dealing with emergencies and equipment. The practice also had a health and safety policy.

Leadership, openness and transparency

Staff felt that the partners were visible and accessible. There were named staff for lead roles in, for example, safeguarding and infection control. However we found that whilst staff knew who to go to with concerns, and were confident those concerns would be addressed, they did not always feel well supported and there were no clear lines of delegation in the event staff were on leave for example.

Monthly staff meetings had been recently introduced and occasional away days were held. Staff told us that there was an open culture within the practice and they were happy to raise issues but that a regular forum for doing so was not always available.

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

Are services well-led?

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

policies, for example bullying and harassment; whistleblowing and capability which were in place to support staff. Staff knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through in-house patient surveys, reviewing comments on NHS Choices, via the national patient survey and through complaints received. From the national patient survey 2014 we saw that 70% of patients said they would recommend the practice, falling short of the CCG average of 82%; whilst 81% gave their overall experience as good, compared to the CCG average of 88%. The practice had considered these responses, some of which it felt were based on the performance of the former partners, and were considering ways to improve. They had identified key areas for improvement, including increasing the patient list size, improving the overall service delivery standards and expanding services to meet patient demand.

The practice had a patient participation group (PPG) consisting of five members, however no member was available to meet with us at the time of this inspection. We were informed that they usually communicated as a virtual group but on an infrequent basis. Staff told us they had made a number of efforts to recruit new members, but to date had not been successful. We noted that there was nothing on display in the waiting room to invite patients to join the PPG, however the practice website did make reference to the group and provided a link to a PPG introduction document and the outcome of the most recent in-house patient surveys. We saw that the practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example they had implemented a text reminder service. The GP told us they tried to encourage patients to join and during consultations, if patient indicated they may be interested, they were given more details.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and also electronically. Most of the staff team at The Vineyard Surgery also worked at the partner practice. This made it difficult to arrange whole team meetings, and some staff felt that there was not enough allocated 'time out' to discuss and resolve issues.

Management lead through learning & improvement

We looked at staff training records and saw that staff were offered regular training in areas such as safeguarding, infection control and basic life support. Staff said they felt the practice was supportive of training. One of the GP partners told us they had twice yearly staff social get togethers, although not all staff appeared aware of this. A practice newsletter was circulated bi-annually.

The senior partner outlined how they planned to proactively improve the quality of their services. This included retaining the registrars who had trained at the practice and taking on as permanent staff trainees from the local college. This approach had already proved successful, with 75% of the GPs working at The Vineyard and its partner practice having formerly been trainees. One member of staff had trained as a phlebotomist, whilst another was going to train as medical secretary.

The practice was currently a training practice for medical students with plans to extend this to junior doctors in approximately 12-18 months.

Since this provider had taken over the practice, in July 2013, staff had not received regular supervision or annual appraisals and some of the staff team told us they felt unsupported. Information from the senior management level was not always filtering down and reaching all staff. We found an enthusiastic staff team which lacked management oversight and as a result was not as effective a team as it could be.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because learning from significant events, safety alerts and complaints had not been shared with all staff; no regular audits had been carried out to monitor infection control standards, test results were not promptly actioned. and there was no governance framework to support the delivery of good care. Regulation 10 (1) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered person did not have suitable arrangements in place to support persons employed as staff had not received regular supervision or appraisal. Regulation 23 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The registered person did not operate suitable recruitment procedures as not all staff provided proof of identity; references or undergone a Disclosure and Barring check. The Hepatitis B status of all relevant staff had not been confirmed. Regulation 21 (1) (a) (b)