Rawnsley 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?	Inadequate
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

We carried out an announced comprehensive inspection at Rawnsley Surgery on 27 April 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be inadequate for providing safe services and for people whose circumstances may make them vulnerable, requiring improvement for effective and well-led services and good for caring and responsive services. The concerns that led to these ratings apply to everyone using the practice including the population groups of older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students) and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, some incidents that may affect patient safety were not investigated.
- The practice did not have effective processes in place to minimise the risks from infections including those that are healthcare associated.
- We saw poor record keeping. We were told that patients had been offered assessments or treatment, but the actions were not recorded.
- We saw that the care offered to some patients with a learning disability did not meet their needs.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Staff were not always supported to review their performance using appraisals. We saw records where a member of staff had identified personal training needs and felt under supported, little action had been taken to address the situation.

Summary of findings

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

Importantly, the provider must:

- Ensure that the recording, investigation and dissemination of significant events is robust.
- Ensure that risks that may affect patient safety are acted upon to minimise the risk of harm to patients.
- Ensure that risks to patients and staff from infection are minimised by adopting best practice infection, prevention and control guidance. This includes completing, recording and acting upon findings from regular infection control audits.
- Ensure that recruitment checks for staff reflect legislative guidance.
- Provide all staff at the practice with appraisals and the regular opportunity to explore individual training needs relevant to their role.
- Ensure that assessment and care that is offered to patients is recorded and reflects recognised guidance.

In addition the provider should:

- Improve security for the issue and tracking of blank prescription forms to reflect nationally accepted guidelines as detailed in NHS Protect.
- Review the emergency medicines held at the practice, to ensure that they are age appropriate for patients and cover the range of conditions that may be encountered in general practice. .
- Provide all staff with training in the Mental Capacity Act 2005.
- Review the process for recalling patients who require annual health checks to ensure all patients are included and that any refusal is followed up and documented.
- Use a team approach to ensure that the feedback collected from patients is recorded, discussed and used to plan and modify services.

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 did not always record incidents, near misses and concerns. Although the practice sometimes reviewed when things went wrong, the reviews lacked consideration of all the factors involved and any changes made did not mitigate against all possible risks of reoccurrence. Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. For example, the practice had not adopted best practice guidance for infection prevention and control. They had not performed an infection control audit for at least four years. We found further serious weaknesses in the areas of responding to medicines alerts, blank prescription pad handling and staff recruitment checks. Risks to patients, visitors and staff from buildings and the environment had not been assessed. We saw an example of such a risk caused by an uneven car park surface.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were average for the locality. The staff we spoke with displayed a good knowledge of national guidelines, although we saw instances of when they had not been followed. For example, following an abnormal test result a patient was given advice that would not in line with accepted national standards. We also saw that some patients whose circumstances may make them vulnerable did not receive care and treatment that reflected nationally recognised guidance, and any refusal by the patient to care and treatment was not documented. There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required

Are services caring?

Good

The practice is rated as good for caring. We saw that the practice had not engaged with some patients who had a learning disability. 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 staff treated patients with kindness and respect ensuring confidentiality was maintained.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. We saw that feedback provided about services from patients was not always recorded or available to be reviewed and shared with staff. The practice had recently introduced a patient participation group (PPG) to seek the views of patients.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. The arrangements in place for managing risks, were not robust and could compromise patient safety. For example, risks to patients from the building and environment had not been assessed. The practice did not hold any formal governance meetings and issues were discussed at ad hoc meetings. Feedback from patients was not collated or shared with staff. Staff told us they had not received regular performance reviews. We saw an example when a member of staff had expressed concerns about feeling undervalued; these concerns had not been explored or acted on.

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and provided a range of enhanced services. For example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The provider was rated as good for caring and responsive services overall and this includes for this population group. The provider was rated as inadequate for safe services and requires improvement for effective and well-led services. The concerns which led to these ratings 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. Longer appointments and home visits were available when needed. The practice offered annual reviews for patients in this group who needed them. For example, 90% of patients with chronic obstructive pulmonary disease (COPD) had received an annual health assessment. For those patients who had complex needs, practice staff worked with relevant health and social professionals to deliver a combined package of care to meet their needs.

Families, children and young people

Requires improvement

The provider was rated as good for caring and responsive services overall and this includes for this population group. The provider was rated as inadequate for safe services and requires improvement for effective and well-led services. The concerns which led to these ratings 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

Summary of findings

plans. Immunisation rates were in line for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as good for caring and responsive services overall and this includes for this population group. The provider was rated as inadequate for safe services and requires improvement for effective and well-led services. The concerns which led to these ratings 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 held late opening evening appointment clinics each week. They also offered NHS Health Checks to patients aged 40-75 years of age and had performed 302 health checks in the previous year. This performance was 58% higher than the expected levels.

People whose circumstances may make them vulnerable

Inadequate

The practice held a register of patients living in vulnerable circumstances. We saw examples of when patients had not been offered annual health screening or when a refusal to an invite had not been recorded. We saw that all of the patients in this group had been reported as exceptions by the practice for receiving annual health checks and tests. (An exception is recorded when it is not appropriate for a patient to receive the review or they have failed to attend an invite for an appointment on three or more occasions). We reviewed records and saw no documentation of invitations or refusals, although practice staff told us they had invited patients. The records we reviewed showed no evidence of engagement to encourage patients to attend health checks to promote their well-being.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as good for caring and responsive services overall and this includes for this population group. The provider was

rated as inadequate for safe services and requires improvement for effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Eighty-two per cent of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had told patients who experienced poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have experienced poor mental health

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. They all described practice staff as caring, compassionate and helpful. Patients also told us that they were treated with dignity and were involved in decisions about their care and treatment. The majority of the patients we spoke with told us that it was easy to make an appointment and that they are seen quickly.

We collected 47 cards from our comment box left in the practice waiting room before our inspection. The majority of the comments received were highly positive about the experience of being a patient or carer of a patient registered at the practice. We saw that six comment cards were not as positive. Three related to patients experiencing difficulty with collecting prescriptions or medicines from reception or the adjacent pharmacy. The pharmacy is contained within the practice building in the former dispensary, although it not owned or managed by the practice. The other three cards that also contained less positive comments had no common themes.

After our inspection we spoke with a member of staff from two local care homes; two staff members in total. We did this to help ensure we understood the care provided by the practice to the patients who live in the care homes. The members of staff told us that the GPs were proactive in visiting the patients regularly and assessed their care needs. They also told us that the GPs would visit in more urgent circumstances. One staff member did tell us that there were sometimes communication problems between the practice and pharmacy that meant medicines for patients were not always ordered in a timely way. The staff we spoke with both told us that the GPs always treated patients with kindness, dignity and respect.

We reviewed national data from the latest GP national patient survey, published in January 2015. The survey involved 326 patients at the practice with 126 returning surveys on their opinion on the care and service given at the practice.

The national data showed that patients were satisfied with access to appointments at the practice. For example 92% of patients found it easy to get through to the practice by telephone; this was higher than the clinical commissioning group (CCG) average of 80%. Also, 96% of patients felt that the last appointment they were given was convenient for them.

We saw that patient satisfaction for the care they received was high. For example, 98% of patients had confidence in their GP and 85% said that the GP was good at treating them with care and concern. Patients were satisfied with the care the practice nurse provided. All of patients who completed the survey said they had trust and confidence in the practice nurse. Also, 95% of patients felt the nurse was good at listening to them.

Areas for improvement

Action the service MUST take to improve

Ensure that the recording, investigation and dissemination of significant events is robust.

Ensure that risks that may affect patient safety are acted upon to minimise the risk of harm to patients.

Ensure that risks to patients and staff from infection are minimised by adopting best practice infection, prevention and control guidance. This includes completing, recording and acting upon findings from regular infection control audits.

Ensure that recruitment checks for staff reflect legislative guidance.

Provide all staff at the practice with appraisals and the regular opportunity to explore individual training needs relevant to their role.

Ensure that assessment and care that is offered to patients is recorded and reflects recognised guidance.

Action the service SHOULD take to improve

Improve security for the issue and tracking of blank prescription forms to reflect nationally accepted guidelines as detailed in NHS Protect.

Summary of findings

Review the emergency medicines held at the practice, to ensure that they are age appropriate for patients and cover the range of conditions that may be encountered in general practice.

Provide all staff with training in the Mental Capacity Act 2005.

Review the process for recalling patients who require annual health checks, to ensure all patients are included and that any refusal is followed up and documented.

Use a team approach to ensure that the feedback collected from patients is recorded, discussed and used to plan and modify services.

Rawnsley Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a second CQC inspector, a GP 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.

Background to Rawnsley Surgery

Rawnsley Surgery is situated within the village of Rawnsley in Cannock, Staffordshire. The area has strong and historical links to industry, in particular coal mining.

The area has similar outcomes to the England averages in area profile data from Public Health England from 2011-2013. The data compares outcomes living in the area including life expectancy and deprivation.

The practice has an all-male partnership of two GPs, who also employ a female GP to provide two clinic sessions each week. There is a female full time practice nurse. The administrative team comprises seven staff including the practice manager who looks after the day to day running of the practice. A part time domestic cleaner works on a daily basis to clean the premises.

There are currently 4,300 patients registered at the practice. The number of patients has risen by nearly 1,000 in the last four years.

The practice holds a Personal Medical Services (PMS) contract with NHS England and has extended its contracted obligations to provide enhanced services with both Cannock Chase Clinical Commissioning Group (CCG) and Public Health England. Enhanced services offered include minor surgery, avoiding unplanned admissions and extended opening hours.

The GPs at the practice also provide contracted medical services each day to a local prison. Those services did not form part of the inspection we carried out.

The practice does not provide medical cover for its patients out of working hours. These services are undertaken by Staffordshire Doctors Urgent Care Ltd by contacting 111.

Why we carried out this inspection

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 April 2015. During our visit we spoke with a range of

Detailed findings

staff including three GPs, a practice nurse, the practice manager and four members of reception and clerical staff. We also spoke with eight patients who used the service. We observed how people were cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

We also spoke with staff from two local care homes that provide nursing and residential care to a number of patients that are registered at the practice after the inspection. We did this to confirm that the care and services met the needs of patients who lived at the care homes, mainly of which were older people or people whose circumstances make them vulnerable.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not have a robust process in place to identify risks and improve patient safety. For example, for alerts about medicines from the Medicines Health Regulatory Agency (MHRA). We asked practice staff about the action taken following alerts that we knew had been issued recently. Two GPs we spoke with were unsure about the role of the MHRA. We asked them to describe and demonstrate the action that had been taken when medicines alerts were received. We used the example of an alert about a particular medicine. This alert was issued in September 2014 by the MHRA to inform clinicians about possible side effects for patients who took higher amounts of the medicine. The GPs were unable to demonstrate sufficient knowledge of the alert and could not show robust action had been taken to ensure that any risk to any patient who took the medicine was minimised. A GP told us that a member of pharmacy staff from the clinical commissioning group (CCG) attended the practice regularly to check that the medicines patients took were appropriate, so they felt that this would be covered within the remit of the CCG pharmacy representative. We asked for assurance that this particular alert had been followed up, but the practice was unable to supply any records or give verbal assurance that the alert had been acted upon.

The practice had a policy for significant events that detailed the actions to take following a significant event being recorded. We saw that the practice did not follow this policy for all significant events. Practice staff told us that they used a template to report significant events. On completion, the forms were submitted to the practice manager for investigation and discussion. The practice manager told us that they also submitted incidents to the CCG via a computerised system.

We reviewed two completed significant event report forms from the previous two years and two incident submissions to the CCG via the computerised system. The records we reviewed showed that the practice did not consistently apply the actions in the significant event policy or on three occasions identify all of the factors that led to the occurrence. For example, the practice had not completed a significant event form or held a review following an occurrence when a patient had an abnormal blood test result that may have caused them harm. This issue had been raised by another healthcare provider, who expressed concern that the care and treatment given to the patient by the practice was not appropriate. We saw other records that indicated the practice did not feel that the incident was a significant event as they felt that the patient had not followed the advice given to them by a GP. The recorded advice we saw was not consistent with National Institute for Health and Care Excellence (NICE) guidance. We asked to review other records to confirm that the actions taken by the practice in this incident were appropriate. The practice could not supply these at the time of the inspection as they were unable to recall or identify the patient involved. The practice contacted us two working days after the inspection to inform us that they had identified the patient and were planning to record the occurrence as a significant event and follow their policy in investigating the occurrence.

Learning and improvement from safety incidents

We saw that the system in place at the practice did not always promote learning and improvement following safety incidents.

The practice did not hold any formal meetings for staff to discuss issues that may affect patient safety. The practice manager told us that staff interaction was constant and that learning points and information were always shared. We asked staff about the process for reporting, discussing and learning from safety incidents. All were able to describe the process although none had ever recorded a safety incident. No member of staff, with the exception of the GPs and practice manager, was able to recall a recorded incident or any changes that had occurred as a result of a significant event.

We reviewed the learning points from significant event recording forms and saw that they were not comprehensive. For example, the records of an incident regarding a delayed diagnosis for a patient did not fully explore all the factors of the incident. We saw that the recorded discussion was defensive and did not address the main issue of a delayed diagnosis. We saw that some positive action had been taken in relation to the incident for example additional training in record keeping for the member of practice staff involved.

Are services safe?

The practice manager told us that they shared alerts such as National Patient Safety Alerts (NPSA) with colleagues by email when relevant to the practice. They were able to describe the actions they would take in the event of a NPSA received that was relevant to the practice.

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 all staff had received relevant role specific training on safeguarding. 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. We saw that contact details for local safeguarding teams were easily accessible. The practice had a dedicated GP as the lead contact in safeguarding vulnerable adults and children. All staff we spoke with were aware of who the nominated safeguarding lead was.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children classified by social services as being at risk.

All of the staff at the practice acted as a chaperone when required. 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. We saw that all staff had received relevant training and criminal records checks through the Disclosure and Barring Service (DBS). All of the staff we spoke with were able to describe the need and reasons for a chaperone. They could accurately describe the process, including where to stand, how to record the offer and the patient's consent in records. The practice displayed notices advertising the availability of a chaperone if required.

Medicines management

We reviewed the process of receiving, storing and issuing prescriptions at the practice. We saw that the handling of both blank computerised and individual prescription forms did not meet national guidelines. The NHS Business Authority guidance "NHS Protect" provides guidance to staff members in all roles and healthcare settings who handle or issue prescriptions. The practice was not following this guidance. The practice did not keep records to track the issue of prescription pads within the practice. The records we reviewed did not accurately and clearly show the number of blank prescription pads in stock. We also saw that there were no records of the person issuing or receiving prescription pads. The practice did not have a system in place to monitor that amount of prescriptions pads that were ordered and the number received was consistent with the amount of prescriptions that had been used. The result of blank prescription pads not being handled robustly could lead to misuse and could cause harm by individuals obtaining medicines that they are not entitled to receive.

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures. The policy described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines, and they were maintained within the required temperature range.

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

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We saw that although the premises appeared visibly clean and tidy, there were examples that steps had not been taken to minimise the risk of avoidable infection to patients, staff and visitors.

The practice had not performed an infection control audit within the previous four years. We were told an infection control audit had been completed in approximately 2011 but a copy of this was not available for us to see. The practice did not follow national guidance on infection control as detailed in the Code of Practice on the

prevention and control of infections and related guidance (Department of Health, 2010). For example, the practice did not have a designated, suitably trained person with lead responsibility for infection prevention.

We saw examples in a treatment room that taps in a hand washing sink were not of a recommended standard as they required a turning action to activate them. Nationally accepted guidance suggested to activate taps the action would be best performed by sensor or by using a person's elbows. This would help to avoid a person leaving bacterial or viral pathogens (germs) on the surface that would be touched by the next person who used the sink. We also saw that disposal bins for used needles and sharp instruments were not dated to indicate how long they had been in operation.

The practice employed their own domestic cleaner and had a daily cleaning schedule visible in the staff room. An erasable laminated sheet was displayed in each room. We saw that in the treatment room we reviewed, the cleaning schedule had not been completed for the day of inspection; this was after the morning cleaning should have taken place.

We looked at staff records to establish if staff had received vaccinations to minimise the risk of patients and staff from blood borne infections, for example Hepatitis B. Hepatitis B is a blood borne virus that can be transmitted from one person to another via bodily fluids transfer. In the three clinical staff records we saw, two did not contain the information of immunity and one showed that the clinician was identified some years before as having no immunity to Hepatitis B. One member of clinical staff was able to produce their immunity status, although the practice had no oversight of this.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had soap dispensers, paper towels and hand gel dispensers available.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had suitable 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.

All portable electrical equipment was routinely tested and displayed stickers indicating the date of the last test. We saw evidence of calibration of clinical equipment. One example was an electronic blood pressure measuring device.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitments checks had not always been undertaken prior to a staff member commencing employment. For example, a part time GP, regularly employed at the practice had not had character references, an employment history or proof of identity checks undertaken. These checks are required to be done under Health and Social Care legislation. The purpose of performing thorough recruitment checks is to minimise the risk of harm to patients caused by staff that have previously provided poor care. The practice manager described the part time GP as a locum and not a regular member of practice staff. NHS Employers produced guidance on the appointment and employment of NHS locum doctors in August 2013. The guidance places the ultimate responsibility on the employer to ensure that a locum GP is suitable for the role. The practice had not met four out of the six employment standards detailed in the guidance on that occasion.

We saw that copies of the professional registration certificates held by the practice for each member of clinical staff were out of date. A GP, nurse or other health professional must hold professional registration in order to provide care and treatment to patients. We subsequently checked and confirmed that all clinical staff at the practice held current professional registration with the appropriate body.

The practice manager told us about the arrangements for planning and monitoring the number of staff needed to meet patients' needs. The minimum requirement for reception and telephone duties was two members of staff. This was to ensure that patient queries and telephone calls were answered promptly and also to prevent staff working alone.

Inadequate

Are services safe?

The practice employed an experienced practice nurse and had recently advertised for a healthcare assistant to provide support with some nursing duties. A part time practice nurse had recently left the practice following a period of absence. We asked about the arrangements for patients if the practice nurse was unable to attend work or had taken leave. The practice manager told us that the nursing duties would be covered by the GPs. We spoke with the practice nurse who told us that they had been off work and duties such as blood sample taking had been covered by the GPs.

Monitoring safety and responding to risk

The practice did not have a system in place to identify, manage and monitor risks to patients, staff and visitors for hazards in the practice building and grounds. We saw an example of such a risk in the car park of the practice. The surface contained loose chippings and pot holes were evident. This may cause a patient, visitor or staff member to trip and could result in injury.

We saw that the processes for other risks, for example infection control, security of prescriptions and medicines alerts were not effective or had not been carried out.

The practice had managed some risks, for example the risk from legionella, equipment suitability and storage of vaccines.

We saw that staff were able to respond to changing risks to patients including deteriorating health and medical emergencies. The staff we spoke with were able to describe a recent incident when a medical emergency had taken place and how they had provided treatment until an emergency ambulance arrived.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received recent training in basic life support. Emergency equipment was available at a secure central point. Equipment included oxygen, a nebuliser (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There were a number of pulse oximeters available (to measure the level of oxygen in a patient's bloodstream). All the staff knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were stored within a secure central area of the practice and also available to each GP in a locked carry bag. The practice did not have all the medicines needed to treat the range of medical emergencies that may occur. We saw that medicines to treat anaphylaxis (allergic reaction) and convulsions (when a patient experienced a seizure/fit) were held. We saw that there were some medicines that had not been included in the practice's emergency medicines stock. An example was Benzylpenecillin, this medicine would be given to a patient with a life threatening infection in the blood and lining of the brain (bacterial meningococcal septicaemia). Early administration of the medicine is known to improve the outcomes for patients with the illness, who are commonly younger although any age range of patient could be affected. The practice did not also stock any medicines to treat hypoglycaemia (low blood sugar, which often occurs quickly). Other emergency medicines we saw were not in suitable for administration for young children as the strength was too high. For example, the strength of salbutamol (a medicine to help relieve the symptoms of worsening asthma) was only suitable for children above the age of five. This may result in a delay in providing medicine to a younger child who experienced difficulty in breathing associated with worsening asthma or an allergic reaction. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice did not store a copy of the plan off site which meant that if the building was not accessible due to an incident or occurrence staff may not be able to follow the plan. The practice manager told us that they planned to keep a copy of the plan off site in the future.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse we spoke with showed an understanding of best practice guidelines from the National Institute for Health and Care Excellence (NICE) and knew how to access them. We were provided with examples of care that reflected NICE guidance, for example the care of patients with diabetes.

However, we saw an example of care and advice that had been provided to a patient that would not be considered best practice guidance. The occurrence was after an abnormal blood test was received for a patient. Practice staff had discussed this issue and had not addressed the key issues by benchmarking the care provided nationally accepted practice. The GPs agreed, when we raised it with them, that their discussion, reflection and documentation of this occurrence was not thorough and said they aimed to improve this in the future.

A GP told us that a member of the medicines optimisation team from the clinical commissioning group (CCG) attended the practice regularly. This was to provide advice and check the patients had received medicines that were appropriate and there was no unusual pattern of prescribing. We looked at national data from the National Health Service Business Authority (NHSBA) from 2013 /2014 and saw that prescribing levels for antibiotic prescribing and hypnotic (sleeping tablets) medicines were in the expected range.

We looked at data from the quality and outcomes framework (QOF) for 2013/2014. We saw that the practice had achieved 95.6% of the QOF points available to them, this was better than the England average of 94.2%.The practice had just completed their submission for the year 2014/2015, however this data was not available at the time of our inspection due to computer system problems. 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.

We saw that all patients with a learning disability (Down syndrome) who received a blood test to check their thyroid function levels were reported as exceptions in QOF to receiving the test. Thyroid disease is more common in patients with Down syndrome, best practice guidelines from the Royal College of General Practitioners (RCGP) suggest thyroid levels should be checked yearly for this group of patients. The exception rate refers to the exclusion of patients who did not receive the test due to reasons that included patient refusal. We saw that the number of patients on the register for this QOF area totalled eight patients. A GP told us that patients were always invited for annual reviews, although it was sometimes challenging to get patients to attend. Due to the concern that patients in this group had not received care that had met their needs, we reviewed two computerised medical records to ensure that the care this group of patients received was appropriate. The two medical records reviewed showed that one patient had no documented invite or refusal for an annual health assessment or blood test for two years. We also saw that one patient had recently had a thyroid hormone level test, although they had not previously had one since 2005. Again there was no documentation in the notes to record any invite or refusal.

We reviewed other data from QOF and saw that other groups of patients received annual health assessments was broadly in line with local and national averages. For example 72% of patients with diabetes had a longer term blood sugar control test result lower than highest acceptable limit. The national average was 78%.

A GP told us that patients who experienced poor mental health were supported by using nationally recognised scoring tools to establish the severity of symptoms. We saw that the annual health review rate for patients on the practice register for poor mental health was 97%,which was better than the England average of 87%.

The practice was signed up to a number of enhanced services to provide services that are above the contracted requirements of a practice. An example was the avoiding unplanned admissions (AUA) service. The practice had identified over 80 patients at the highest risk of emergency admission to hospital and implemented individual care plans. A GP told us that the care plans were reviewed every three months or sooner if required. If a patient on the AUA register was admitted to hospital, on discharge they were contacted by a GP to discuss their care needs within three days. A member of the practice team showed us an example of an AUA care plan. We saw that an alert was evident on the record detailing the patient was overdue for a medication review. We saw that the patient had been taking medication for anaemia (low red blood cell count)

Requires improvement

Are services effective?

(for example, treatment is effective)

for two years and had not received a documented review, any follow up tests or any recorded indication why the medicine was still needed to be taken. A GP and the practice manager told us about the steps that are taken when medication items are requested on repeat prescription. The procedure was clear, both the GP and practice manager felt this was an unusual occurrence and planned to investigate the reasons for the medication review being overdue for this patient. Other enhanced services included minor surgery, venepuncture (blood sample taking) and monitoring of blood thinning medication.

We reviewed nationally available data from the Health and Social Care Information Centre (HSCIC) from 2013/2014 and saw that emergency admissions for patients at the practice were in line or lower than the national average.

The GPs told us that they use national standards for the referral of patients with suspected cancer to be seen by a hospital specialist within two weeks. Data from Public Health England from 2014 showed that the rates for using nationally accepted standards for patients with suspected cancer were in line with the local and national average.

Management, monitoring and improving outcomes for people

Practice staff told us they all played a part in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and managing child protection alerts. They told us that patients were contacted by the practice to make an appointment for a health review and also used their contact with patients opportunistically to arrange health reviews.

The practice showed us two completed clinical audits that had been completed in the last year. An example was an audit of female patients who had been prescribed the combined oral contraceptive medicine. The audit looked at whether the prescribing clinician was obtaining an adequate medical history from the patient to minimise the risk of side effects. The first audit completed in 2014 involved 39 patients. The first cycle of the audit concluded that 63% had a correct record of a medical history being taken. The findings were shared with the clinical team to help improve the obtaining and recording of medical history. The audit was repeated in 2015 and showed that 84% of patients had a recording of a suitable medical history being recorded. A GP told us that they planned to repeat the audit again as they aimed to achieve 100%.

A GP told us that they kept records of minor surgery which included written consent, complication and infection rates. They told us they did this to identify any trends in complications or infections after the surgery has taken place. We were told that no trends had been identified.

Patients who were approaching the end of their life were discussed at regular multidisciplinary team meetings at the practice. We saw records that showed that care was discussed and adapted to meet the needs of patients in this group. We saw that emergency unplanned admissions for patients that included those approaching end of life were lower than the national average.

A GP told us that they attended monthly CCG meetings that involved benchmarking the practice performance data against other practices. They told us that they were comparable to other practices for rates of referral of patients to outpatient clinics and emergency admissions in the area. We were unable to confirm this as the information was not available on the day of inspection.

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 courses such as basic life support and fire safety. We noted that a GP was studying to obtain a higher level qualification in diabetic care and planned to enhance the service provided to this group of patients. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We spoke with staff and reviewed records that showed staff at the practice had not received annual appraisals since 2012. All staff members told us that they felt supported and could approach any of the GPs or practice manager with any training needs. We reviewed records which showed a staff member had expressed interest to pursue further training to develop their role to be able to support others in the practice with learning. This expression had been made in 2012; we spoke with the staff member who confirmed that the training had not been offered.

Requires improvement

Are services effective?

(for example, treatment is effective)

All staff attended protected learning time provided by the local CCG. A practice nurse told us that they received useful information and updates from the monthly sessions.

We saw that the experienced practice nurse had undertaken a number of training courses to provide care to patient groups. For example, they held a diploma in asthma and diabetic care. We noted that in the five years of working at the practice, the practice nurse had not been supported to develop beyond annual training such as fire safety and basic life support. This was evident in the lack of annual appraisals or any training plan for the last three years. We also saw that the practice had not acted following a previous expression of interest in obtaining additional training.

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. All of the practice staff had a role in processing and acting on any issues that arose from communication with other care providers. We saw that the GPs were up to date on reviewing blood results and following up on hospital letters.

Multidisciplinary meetings were held every six to eight weeks to discuss the needs of patients approaching the end of their life. The meetings were attended by the GPs, practice nurse, community nurses and the palliative care lead nurse. Patients were reviewed and changes in their condition or treatment were discussed and documented. We saw records of the meeting which showed effective communication and showed change in care planning to meet the needs of patients.

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

We were shown the system for recording special notes that were entered into the shared system. An example of this was information regarding patients approaching the end of their life. Clinical information and wishes were recorded and uploaded to the system. This meant if the patient needed assistance when the practice was closed the out-of-hours GP provider would have access to the information.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice also provided the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All of the staff we spoke with were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. None of the clinical staff we spoke with had received formal training in the Mental Capacity Act 2005, although they understood the key parts of the legislation and were able to describe how they implemented it in their practice.

We saw that the practice used a template to record consent for minor surgical procedures. The template was a written record of the risks, benefits and complications of the procedure. The practice nurse showed us examples of the templates, after completion they were scanned onto the patient notes and stored securely.

We saw records of when decisions that required capacity assessment had not been recorded. For example, a GP told us that a patient with a learning difficulty had not attended

Requires improvement

Are services effective?

(for example, treatment is effective)

a health review. There was no record of the invitation or a discussion that assessed that the patient had understood the reason for the assessment or the benefits the proposed health check.

The GP told us that patients with dementia were supported through the use of care plans that they were involved in completing. The latest available QOF data from 2013 /2014 showed that 89% of patients with dementia had been reviewed in the last year.

We asked clinical staff about their understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). One member of clinical staff we spoke with was unsure of the meaning of Gillick competence, although was able to describe a basic understanding of the principles. The other clinical staff we spoke with were able to accurately describe Gillick competencies.

Health promotion and prevention

The practice offered a range of health promotion enhanced services at the practice in response to the CCG and Public Health England making these available. Examples were smoking cessation and weight management.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We reviewed the latest available data from QOF for the period of 2013/2014, to establish the practice performance for providing health promotion and prevention.

We saw that the practice cervical screening uptake rate was 82% which was higher than the CCG and England average of 77%. The practice nurse told us that she followed up patients who did not attend to highlight the importance of regular screening.

The practice nurse performed child immunisations. We saw that immunisations rates for all ages of children were broadly in line or slightly lower than the CCG average. For example, at two years of age the uptake rate of the measles, mumps and rubella (MMR) vaccine was 95.6% compared with a CCG average of 98.1%.

NHS Health Checks were provided to eligible patients in the age range of 40 to 74 years. We saw records to show that the practice had performed 302 health checks in the previous year. This performance was 58% higher than the expected levels. As a result 12 patients had been prescribed medicine to reduce their cholesterol levels. Three patients were newly diagnosed as diabetic and four patients were diagnosed with previously unknown high blood pressure. We also saw that 93% of patients aged 40 and above had received a blood pressure checked within the last five year

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed most recent data available for the practice on patient satisfaction. This included information from the GP national patient survey published in January 2015. The survey collated the responses of 126 patients at the practice from 328 survey questionnaires sent out. The practice had also conducted an internal patient survey in October 2014, the results of this survey were positive although the comments related to one GP and were personal to the care they provided.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also comparable with the local and national average in its satisfaction scores on consultations with GPs with 92% of practice respondents saying the GP was good at listening to them and 90% saying the GP gave them enough time.

We saw that patients rated the care they received from the practice nurse highly, for example 95% of patients felt the nurse was good at listening to them. Also 100% of patients surveyed had confidence and trust in the practice nurse.

We asked patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 47 completed cards and the majority were positive about the service experienced. Most patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All said that staff treated them with dignity and respect.

We spoke with eight patients during our inspection. All described practice staff as caring, helpful and compassionate. All of the patients we spoke with said they had confidence in their care and that they were treated with dignity.

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

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located behind glass partitions and away from the reception desk which helped keep patient information private. The practice waiting room was small which made it difficult to ask patients and visitors to approach the reception desk one at a time. Staff told us that they could arrange a room if patients wished to discuss a personal matter and advertised this. None of the comment cards we received or patients we spoke with raised any concern with confidentiality in the reception area or the practice building in general.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients at the practice responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results showed that respondents rated the practice at higher satisfaction levels than the local and national average in these areas. For example, data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. We also saw that the satisfaction levels for the practice nurse in those areas were in above the local and national averages. For example 91% of practice respondents felt the nurse had involved them in their care which compared favourably against the CCG average of 79%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also very positive and aligned with these views.

Good

Are services caring?

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

We saw that decisions about care and treatment had not always been recorded effectively. For example, A GP told us that all patients on the learning disability register were offered annual health assessments. We could not verify this as in the records we reviewed there was no recording of an invitation or refusal.

Patient/carer support to cope emotionally with care and treatment

All of the GP national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 85% of respondents to the national patient survey said they felt that the GP who treated them, did so with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted individual examples when staff responded compassionately and provided support when required.

Notices in the practice waiting room and information on the website also signposted patients to a number of support groups and organisations.

Families who experienced a bereavement were contacted where appropriate. A GP told us based on the individual circumstances a GP would call the families if this was suitable. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. One of the comment cards we received contained positive comments about the support provided following a bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We spoke with patients, carers of patients and reviewed data from the latest GP national patient survey published in January 2015. All of these sources showed that patients felt that the practice met their needs.

The practice offered enhanced services to provide patients with extra services than their basic contractual requirements. These included extended opening hours, blood sample taking and unplanned admission avoidance.

The NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We spoke with staff from two local care homes. Both told us that the GPs met the needs of their registered patients in the care home. They told us that GPs visited on at a least a weekly basis and always made additional visits to those who required them when requested.

We asked the practice manager about how the practice was using the views of patients to plan their services. They told us that they had recently set up a patient participation group (PPG) to use the views of patients in future planning. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We asked to speak with members of the PPG, who were due to meet for the first time after our inspection. No members were available to speak with us due to them having prior commitments.

The practice had a suggestion box for patients to make suggestions. The suggestions were collated by the practice manager and handed to the lead GP. We were unable to view any records to confirm this happened. The practice manager told us that they did not formally record the feedback received, although it did not amount to many comments each year. We asked about the nature of comments and how these were acted upon and discussed with staff. The practice manager told us that the comments were nearly always positive and that any comments were discussed with staff informally.

Tackling inequity and promoting equality

The practice had access to telephone translation services for patients who did not have English as their first language.

All facilities at the practice were situated in the single storey building. The access to the practice was level and had automated doors to assist patients to enter the premises with minimal hindrance. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. There was a hearing loop available for patients and visitors with hearing aids.

The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respect for diversity.

Access to the service

The core opening times of the practice were Monday to Friday 8am to 6:30pm, during this time the telephone lines and reception desk were staffed. The practice offered extended appointments, which benefited patients of a working age and children of school age, from 6:30pm to 8pm on a Monday, 6:30pm to 7pm on a Wednesday and Thursday.

Patients were able to make appointments in person, by telephone or online if registered for this service. Appointments were able to be booked both in advance and on the same day. We saw that all the GPs had a good availability of appointments available, which included appointments able to be booked on the same day. Staff told us that if appointments on a day were full and a patient requested one, they would book the patient a telephone appointment. A GP would call the patient back and decide on the best course of action, this included fitting the patient in to be seen if they needed this.

Practice staff told us home visits were available to those who needed them. We spoke with staff from two local care homes who told us that the GPs visited patients in their care setting weekly and would always visit more often if requested.

Data from the national patient survey showed that patients were positive about access to the practice and that satisfaction scores were higher than the local and national averages. For example, 92% of patients surveyed found it

Good

Are services responsive to people's needs?

(for example, to feedback?)

easy to get through to the practice by telephone; this was significantly higher than the CCG average of 80%. Also 96% of patients found their last appointment made was convenient for them.

The overwhelming majority of the patients we spoke and the comments card we received were positive about the appointments system. We received two comment cards that praised care at the practice although one said appointments can run behind sometimes and one said that appointment availability was not as good as more patients had joined the practice.

When the practice was closed, a telephone message directed patients to the out-of-hours service by calling 111. We saw information in the practice waiting room informing patients on how to arrange help out-of-hours and patients we spoke with were aware of the arrangements.

Listening and learning from concerns and complaints

The practice had a system and policy in place for handling complaints and displayed information in the practice waiting room and on the practice web site to explain how to make a complaint.

We reviewed records of complaints made at the practice during the previous year. This amounted to one complaint. We saw that the complaint was acknowledged and responded to within acceptable timescales and that the points of complaint were answered. The response letter did not contain the actions that the complainant could take if they were not satisfied with the complaint response.

We spoke with staff at the practice about the method for patients to make a complaint. All of the staff told us that that they would listen to the concerns made, try and resolve any issues as best they could and would request the person complaining to write their concerns in a letter to the practice manager. None of the staff we spoke with could recall the last complaint made.

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 did not have a written vision and values statement, although all staff were able to explain the essence of their individual views of the values and how they contributed to patient care. For example, the practice manager told us that the practice strived to provide the best care and access to care for their patients.

We spoke with eight members of staff, all told us that they aimed to treat patients with care and compassion.

The practice manager told us that the practice patient list size had grown by 1000 patients in the previous four years. They felt this was due to the practice being well regarded locally and that it had a reputation for providing good access and continuity for patients.

Governance arrangements

We saw that the governance arrangements at the practice were not robust and may affect the safety of patients. For example, the practice had not done an infection control audit for at least four years. We saw examples of practise that could increase the spread of infection. One example was taps in a hand washing sink were of a twist top mechanism. When washing hands a staff member would need to use their hands to activate the water, this could lead to spread of infection to the next person who used the taps.

The practice had no formal method of assessing the risk to patients, staff and visitors from the building and environment. For example, the practice car park had an uneven surface with pot holes evident. Risks from environmental conditions such as poor weather were not assessed or mitigated.

The practice stored blank prescriptions in a secure area. However there was no tracking system for blank prescriptions after they were received in the practice building. The practice did not comply with NHS guidance on security for blank prescription pads. The practice had no oversight of the number of blank prescription pads in stock and who blank prescription pads were issued from and to within the premises.

We saw that the recruitment checks undertaken before a member of staff started work at the practice were not robust and had weaknesses. There were examples where character references had not been undertaken, employment history had not been checked and the current professional registration of clinical staff was not known or recorded.

The practice had a number of policies and procedures for staff to refer to for guidance. We reviewed four policies, all were shown to be in date although they did not always address the risk associated with the subject or the guidance in the policy had not been followed. For example, the infection control policy did not contain any guidance on performing ongoing audit of the premises and practices to ensure they reflected best practice guidance. Another example was the infection control policy stated that clinical staff had initial pre-employment screening and ongoing monitoring of their immunity status to blood-borne viruses such as Hepatitis B. We reviewed three staff records and saw that the immunity of staff was not recorded and in one example, we saw that a previous blood test result had revealed that the staff member was not immune to Hepatitis B. No recorded action had been taken in relation to this area of risk.

We saw that the practice had a policy for significant events that they did not always follow. We saw examples of incidents that were included in the policy definition of a significant event that had not been recorded. The policy detailed that significant events would be discussed at clinical meetings. These meetings were not formally recorded. The practice manager told us they do occur at irregular intervals, although they did not formally record the actions.

There was no evidence that governance was regularly discussed as practice meetings were not held. The practice was managing some other risks such as equipment calibration and testing, fire safety and the assessment of legionella.

Leadership, openness and transparency

The staff we spoke with told us that the GPs were friendly and approachable and that the practice manager had an open door policy. They felt that they could go to the practice manager for help and support.

One member of staff we spoke with told us that the GPs had a very visible presence in the practice and proactively engaged with staff.

Are services well-led?

Requires improvement

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

The practice manager told us that issues that were relevant to the practice team were shared in informal meetings and that individual issues were dealt with confidentiality.

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

The practice had gathered feedback from patients by a number of methods. The practice had a suggestions box in the waiting room, patient suggestions were collected by the practice manager and handed to the GP partner. It was not clear what happened with the comments after this. There was no record or examples of the comments being shared with staff. The practice did not record this information or identify any trends although the practice manger told us that the comments were always positive. We could not confirm this as there were no records kept or the comments submitted were not available to be reviewed.

A member of staff from a local care home we spoke with and three individual comment cards said that sometimes there could be confusion between the neighbouring pharmacy and the practice regarding prescriptions. We asked staff about complaints or concerns that patients express, two members of staff told us that patients could sometimes be frustrated by prescription issues. There was no evidence of these issues being recorded or discussed within the practice. The practice manager told us that the issue was known and discussed, however the practice felt the issue was with the pharmacy. Practice staff could not detail any action taken to explore or resolve the concerns expressed by patients.

The practice had recently set up a patient participation group (PPG). The group had not met at the time of our inspection. The practice manager told us they had introduced the group to get a direct link to patients, although they felt they understood patients' needs and this was reflected in high national patient survey scores.

The practice had commissioned an internal patient satisfaction survey on the care provided by one of the GPs which was made available to us. The survey was undertaken in October 2014 and contained positive themes about the individual clinician, although did not reflect the patients experience of other clinicians, practice staff or experiences on appointments.

The practice manager told us that feedback from staff was encouraged and given. Staff we spoke with told us that they felt able to give feedback to the practice manager and GPs at any time.

Management lead through learning and improvement

Staff at the practice attended regular protected learning time training through the clinical commissioning group (CCG). Staff told us that the training provided was relevant to their role.

All of practice staff we spoke with told us that they had not had an appraisal or personal development plan in place since 2012. We saw records of a member of nursing staff's appraisal from 2012. The staff member expressed that they felt unsupported and wished to develop by obtaining additional training. The practice had not supplied the training or documented any offers of support or exploration of addressing the staff member's feelings of lack of support. We spoke with the member of staff, who told us that although they felt able to approach the practice management team, training opportunities were limited due to a high workload. We saw that in five years of employment within the practice, the member of nursing staff had not been supported to develop beyond the expected levels of training that took place. These included basic life support training and fire safety training. The GPs and practice manager told us that they recognised that this was not acceptable and they aimed to change the process in the future.

We saw weaknesses in the process of discussing, learning and improving following significant events, complaints, concerns and changes to guidelines. None of the practice staff we spoke with were able to recall a recent significant event or complaint, although they could recall concerns expressed by patients. These concerns were not recorded and there was no evidence that the comments led to discussion or any change in practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not operated effectively because serious event investigation, recording and information sharing was not completed on all occasions. Investigation had not always been completed in a comprehensive way. Regulation 17 (2) (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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not operated effective recruitment procedures, as they had not undertaken checks as detailed in Schedule 3 in relation to obtaining satisfactory character references, employment history, professional registration status and pre-employment health screening. Regulation 19 (3) (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 18 HSCA (RA) Regulations 2014 Staffing Staff had not been given appropriate support by means of an appraisal or personal development plan for at least three years. Regulation 18 (2) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider did not assess the risk to patients, staff and visitors from infection, including those that are health care associated for a period of least four years. Risk assessment from unsuitable premises, medicine alerts, blank prescription handling had not been undertaken for the same time period.

Regulation 12 (2) (a) (b) (h)