Farningham Surgery

Quality Report

The Surgery
Braeside
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Farningham
Dartford
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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?	Good
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

A comprehensive inspection was undertaken at Farningham Surgery on 30 October 2014.

Overall, we found that the practice requires improvement.

We found that the practice offered a good level of service to all of the patient population groups who received services and our key findings included:-

- patients received an effective, responsive service that identified and met their needs
- that patients had good access to the services and GPs
- that the appointments system worked well and availability of appointments was good
- patients felt they were treated with respect and dignity
- that staff were helpful, kind and considerate to their needs
- that patient privacy and confidentiality was maintained.

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

Importantly, the provider must:

- Review the arrangements for the management of medicines in relation to the authorisation of vaccines administered by health care assistants within the practice.
- Review the training undertaken by health care assistants to ensure it is appropriate to their role and in the administration of vaccines where they are authorised and directed to carry these out.
- Update and follow the practice recruitment policy to ensure all checks are in place when staff are employed at the practice.
- Review systems and processes for monitoring the quality and safety of the services provided, by undertaking regular audits, including infection control

Summary of findings

and premises checks and training audits, and take steps to ensure risks are identified, assessed, monitored and managed appropriately, including risks associated with legionella.

In addition the provider should:

- Review the record keeping arrangements used in the practice to record the actions taken by staff following the receipt of safety alerts.
- Ensure that accurate records are kept to identify which staff have attended safeguarding training and to what level.

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. Patients were at risk of harm in relation to the management of medicines and associated training for staff. There were also concerns relating to the recruitment checks completed when staff were employed at the practice and concerns in relation to the lack of systems and processes to monitor safety in the practice. For example, by undertaking audits and checks, and in the monitoring of risks, including those associated with legionella.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Most staff had received training appropriate to their roles and the practice was able to identify that appraisals had been completed for all staff. Multidisciplinary working was evidenced.

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 engaged with their local NHS area team and clinical commissioning group to plan service requirements. Patients said they found it easy to make an appointment with a named GP, and that they usually saw the same GP to provide continuity of care, 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 quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had a mission statement and patient charter that set out its aims and objectives and there was a clear leadership structure documented. Staff felt supported by management and were clear about who to go to with issues. The practice had a range of policies and procedures to govern activity and provide guidance. All staff had received an annual appraisal and a review of their performance. However, systems and processes had not been implemented to monitor and manage safety, for example, regular audits and checks. There were no arrangements in place for the management of risks within the practice and there was no evidence that risks were discussed and monitored by the management team on a regular basis.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice had mainly good outcomes for older people when compared to national data. Older people received care and treatment relevant to their age group, including blood tests and blood pressure monitoring and received routine annual health checks to review their medicines and general well-being.

The practice offered proactive, personalised care to meet the needs of older people and was responsive in offering home visits and rapid access appointments for those with enhanced needs. The practice dispensary made weekly deliveries to older people who found it difficult to collect their own medicines from the practice.

We saw that flu vaccinations were routinely offered to older people to help protect them against the virus and associated illness. The practice was pro-active in supporting a local care home for older people and offered continuity of care from a named GP within the practice.

The practice was caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with complex conditions, such as dementia and end of life care. Clinical audits had been undertaken to evaluate outcomes for patients in this group.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice offered nurse led specialist clinics and appointments including asthma, chronic obstructive pulmonary disease (COPD) and diabetes clinics.

Longer appointments and home visits were available for patients with long-term conditions and annual reviews were arranged to check their health and medication needs were being met. Community nurses and staff from the community palliative care team attended regular meetings with the GPs and the nursing staff, which enabled the practice to discuss the needs of patients with chronic and terminal illnesses.

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Summary of findings

Families, children and young people

Good

The practice is rated as good for families, children and young people. Expectant mothers were supported by the midwife linked to the practice and mother and baby clinics were offered for post-natal and baby checks with the GP. The health visitor offered twice monthly clinics at the practice to ensure regular contact with mothers, babies and children, and worked with the GPs in supporting new mothers, babies and children.

Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice was rated good for working age people (including those recently retired and students). The practice had adjusted the services it offered to make them more accessible outside of core working hours. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for patients whose circumstances may make them vulnerable. The practice had historically supported patients from the travelling community and was aware of patients who may have found themselves homeless and required additional support to access health care.

The practice was responsive in providing care in people's homes who found it difficult to attend the practice. The practice had carried out annual health checks and offered longer appointments if required, for example, for patients with a learning disability. The practice worked with multi-disciplinary teams in the case management of vulnerable people and offered information about various support groups and voluntary organisations.

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

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for patients experiencing poor mental health. The practice had effective procedures for identifying patients who had mental health needs and regular checks and

Summary of findings

follow-up contact was made where patients had not attended for appointments. The practice was responsive in referring patients to other service providers for on-going support and there was a range of information available for patients who may require additional support and services.

The practice worked with multi-disciplinary teams and community specialists in providing support to patients with mental health needs The practice staff had received training on how to respond and prioritise appointments for people with mental health needs and adopted a flexible approach in the support it offered, including crisis support.

Summary of findings

What people who use the service say

We spoke with nine patients and reviewed 20 comment cards completed by patients prior to our inspection. All the patients we spoke with during our inspection were very positive about the services they received from the practice. They were particularly complimentary about the staff, and said that they were always caring, supportive and sensitive to their needs, and that they were treated with respect and dignity.

Patients told us that the appointments system worked well for them and that they would be able to get same day appointments if urgent. They said they always had enough time with the GPs and nurses to discuss their care and treatment thoroughly and never felt rushed.

Patients told us that they had no concerns about the cleanliness of the practice and that they always felt safe. Patients said that referrals to other services for consultations and tests had always been efficient and prompt.

There were many positive comments from patients who had completed comment cards. All expressed a high level of satisfaction with the service they had received and the majority commented that staff were efficient, helpful and caring.

Areas for improvement

Action the service MUST take to improve

- Review the arrangements for the management of medicines in relation to the authorisation of vaccines administered by health care assistants within the practice.
- Review the training undertaken by health care assistants to ensure it is appropriate to their role and in the administration of vaccines where they are authorised and directed to carry these out.
- Update and follow the practice recruitment policy to ensure all checks are in place when staff are employed at the practice.
- Review systems and processes for monitoring the quality and safety of the services provided, by undertaking regular audits, including infection control and premises checks and training audits, and take steps to ensure risks are identified, assessed, monitored and managed appropriately, including risks associated with legionella.

Action the service SHOULD take to improve

- Review the record keeping arrangements used in the practice to record the actions taken by staff following the receipt of safety alerts.
- Ensure that accurate records are kept to identify which staff have attended safeguarding training and to what level.

Farningham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Farningham Surgery

Farningham Surgery provides medical care Monday to Friday from 8.30am to 6.30pm each week day and operates extended opening hours until 8pm on Monday and Wednesday evenings. The practice is closed between 1pm and 2pm each day for lunch and to allow staff to process administrative work without interruption. The practice is situated in a semi-rural location in Farningham, near Dartford in Kent and provides a service to approximately 5,750 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the nursing team. There are a range of patient population groups that use the practice and the practice holds a general medical services (GMS) contract. The practice does not provide out of hours services to its patients and information is available to patients about how to contact the local out of hours services.

The practice has one male and two female GP partners and a female salaried GP. There are two practice nurses, two health care assistants who undertake blood tests, blood pressure tests, ECGs, new patient checks and NHS health checks. The practice operates a dispensary and employs five dispensing staff and a trainee dispenser. The practice has a number of administration / reception and secretarial staff as well as a practice manager.

The practice has more patients in older age groups than the local and national average and a lower number of children under the age of four. The number of patients recognised as suffering deprivation is lower than the local and national average. The practice supports a significantly higher number of patients who reside in care homes than the national average.

Services are delivered from:

Farningham Surgery

Braeside, Gorse Hill,

Farningham

Dartford

Kent

DA4 0JU

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.

Detailed findings

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew, including the NHS area team, the locality clinical commissioning group and the local Healthwatch.

We carried out an announced visit on the 30 October 2014. During our visit we spoke with a range of staff including GPs, nursing staff, receptionists and administration staff. We spoke with patients who used the service. We placed comment cards in the surgery reception so that patients could share their views and experiences of the service before and during the inspection visit.

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 used a range of information to improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw examples of incidents that had been recorded by staff, including significant event reports, and we saw the significant event reports recorded and summarised for the previous two years.

National patient safety alerts were received by the practice manager and disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example, medicine safety alerts were forwarded to the dispensary staff, although no records were kept to confirm the actions taken.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and safety incidents. Significant events were discussed at general practice meetings and a dedicated meeting had been held in the last year to review and analyse significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We reviewed some of the incidents and saw that records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example, administrative systems had been reviewed and updated following the mistaken identity of a patient attending for a blood test.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children and vulnerable adults. The practice had a policy for safeguarding both children and vulnerable adults and included procedures for staff guidance and contact information for referring concerns to external authorities. The policy reflected the requirements of the NHS safeguarding protocol and included the contact details of the named lead for safeguarding within the NHS area team.

The practice had appointed a dedicated GP as the safeguarding lead for children and vulnerable adults and staff we spoke with were aware of the lead GP and who to speak to in the practice if they had a safeguarding concern.

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 and raise safeguarding concerns with relevant agencies if required. All staff told us that they had undertaken safeguarding training and GPs confirmed they had achieved level three training. However, from the training records kept at the practice, it was unclear which staff had completed the training and the level achieved. We saw that one of the nursing staff had completed level one training for children and had received training on safeguarding vulnerable adults, whilst records showed that one of the GPs had completed level two in child protection. No other records were available to confirm safeguarding training had been undertaken.

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 subject to child protection plans and older patients who lived in vulnerable circumstances. GPs told us that they liaised with social services to share information in relation to child protection concerns that were identified within the practice and referred older people to other services where additional risks were identified. We were told that the practice had a system for following-up persistent non-attendance for appointments, for example, childhood immunisations.

The practice had a chaperone policy that set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. We saw that this information was clearly displayed for patients' information and the staff we spoke with confirmed arrangements would be made for those patients who requested a chaperone. Most of the administrative staff had received chaperone training and

told us they were aware of the procedures to follow. Those staff who told us that they had not had chaperone training or a criminal records check confirmed they would not be expected to undertake chaperone duties.

Medicines management

We checked medicines stored in the dispensary and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy, although records were not kept to monitor the room temperature and a back-up manual thermometer was not available to check fridge temperatures in the event of a power failure.

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 nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in the specific clinical areas of expertise for prescribing. We were told that health care assistants also administered vaccines at the practice. However, there were no recorded patient specific directions in place that authorised the health care assistants to administer vaccines, in line with legal requirements and national guidance. The practice training records did not show that health care assistants had received the appropriate training to administer vaccines.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was followed in the practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients using their dispensary. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for people to pick up their dispensed prescriptions at the practice and also offered a delivery service for those patients who found it difficult to attend the practice, for example, older people.

Cleanliness and infection control

The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, management of sharps injuries and spillages. The policy was dated June 2013 and we were told that it was under review to ensure the information and guidance was up-to-date. A member of staff was the infection control lead for the practice and we spoke with them. They demonstrated a clear understanding of their role and responsibilities in relation to infection prevention and control. However, they told us that infection control audits had not been undertaken in the practice and this was something they planned to introduce and we saw this was included on the 'practice continuing development plan'.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes and notices were displayed to provide guidance for staff in safe hand washing technique. We saw that domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company. Cleaning schedules were used and completed to identify and monitor cleaning activities and the staff who were responsible for cleaning different areas within the practice.

Staff told us that checks for the detection and management of legionella (a germ found in the environment which can contaminate water systems in buildings) had recently been undertaken by a specialist contractor and we saw evidence

that water samples had been collected for testing. However, the practice did not have a policy or a risk assessment to manage the on-going risks associated with legionella to identify and reduce potential risks to staff, patients and others who used the premises.

Nursing staff we spoke with told us they had received training in infection control and the training records confirmed this. However, there were no records to confirm the infection control training undertaken by GPs at the practice. All staff were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control. Patients told us they found the practice clean and tidy and that they had no concerns about the cleanliness of the premises.

Equipment

Clinical equipment was appropriately checked to help promote the safety of staff, patients and visitors. We spoke with nursing staff, who told us they had responsibility for making sure equipment used in the practice was routinely checked. Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments and that all equipment was tested and maintained regularly. We saw records that confirmed this, for example, records to demonstrate that medicine refrigerators were routinely checked and thermometers calibrated.

Staffing and recruitment

The practice had a recruitment policy for the recruitment and selection of staff employed at the practice, although this did not refer to identification checks and employment history checks. We looked at a selection of staff files and saw that criminal record checks had been carried out via the Disclosure and Barring Service (DBS), in accordance with the practice assessment protocol to consider those roles that required a DBS check. However, some staff files did not contain sufficient documented information about the staff employed at the practice, for example, photographic ID, employment history and sufficient references, as stipulated in the practice recruitment policy. Professional registration checks were undertaken with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) on appointment. However, there was no formal system or audit process to ensure professional registration checks for nurses and GPs were routinely checked and followed up by the practice to ensure they remained up-to-date.

The practice had arrangements for planning and monitoring staffing levels and the skill mix of staff required to meet patients' needs. A rota was planned on a weekly basis to cover the clinical sessions to ensure there were enough staff on duty. The GPs had arrangements in place to cover each other in the event of planned / unplanned absence and locums were used when required. The practice did not have a contract for the supply of locum GPs, however, regular locums were used at the practice to provide continuity of care to patients. We were told that a partner GP had recently retired and the recruitment for a new GP was underway and we saw evidence of this. The staff we spoke with told us that they felt there were enough staff to meet the needs of the patients on a day-to-day basis. Patients we spoke with told us they felt there were always staff available to see them and that they knew the locum GPs used at the practice.

Monitoring safety and responding to risk

The practice had health and safety procedures and information was included in the staff handbook and in induction plans for new staff. However, general routine checks of the building were not undertaken to identify, assess and monitor risks. For example, a fire risk assessment for the building had been completed and was dated 2007. This had not been reviewed or updated to reflect any changes since that time.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We spoke with staff who told us about the procedure they would follow to alert other staff that they had an emergency situation in consultation / treatment rooms. We were told that each room had a 'panic' button that alerted other staff to the emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Inadequate

Are services safe?

The practice had an emergency and business continuity / recovery plan that they were in the process of updating. The plan included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, severe bad weather that caused staff shortages, interruption to utilities, or unavailability of the premises.

Staff we spoke with told us that they had undertaken fire safety training and we saw records that confirmed this. The practice had nominated fire wardens to direct staff in the event of an emergency.

Good

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Bi-monthly practice meetings were held to discuss required changes to clinical practice and revised care / treatment plans were implemented to reflect updated guidance. We were told that comprehensive and detailed patient records were kept on the electronic system and patients who had been assessed as 'at risk', for example, older patients, had care plans in place. Patients over the age of 75 all had a named GP who were responsible for their care and treatment and all patients in this age group with long-term conditions were routinely re-called for reviews or referred to community services for additional specialist support. 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.

The GPs told us they each led in specialist clinical areas such as medicine prescribing and dementia, which allowed the practice to focus on specific conditions, for example, support to a local care home for older people with dementia and associated complex conditions. National data showed that the practice was performing well above average for patients who had been diagnosed with dementia, who had received a review of their care needs in the previous fifteen months.

Management, monitoring and improving outcomes for people

All staff told us that registers were kept to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including dementia, asthma, heart disease, and diabetes. The electronic records system contained indicators to alert GPs and nursing staff to specific patient needs and any follow-up actions required, for example, medicine and treatment reviews. Administrative staff monitored the re-call system to contact patients who were due follow-up tests or reviews. Repeated non-attendance was subsequently passed to the GPs to make personal contact with patients.

The practice had been involved in a pilot project for identifying patients with early on-set dementia and therefore held a higher than average register for patients with dementia. GPs were trained to identify and review patients with memory problems for onward referral to the specialist community nursing team and specialist services who supported patients with dementia.

The practice had monitoring processes in place to manage the care and treatment of patients with long-term conditions such as diabetes, COPD and cancer. Patients diagnosed with cancer and rheumatoid conditions underwent regular blood tests and follow-up reviews.

We were told by GPs that data collected for the Quality and Outcomes Framework (QOF) was reviewed at clinical meetings where information was shared and discussed amongst relevant staff. Comparisons were made in relation to national screening programmes to monitor outcomes for patients. For example, the QOF data for the practice showed that 96% of patients with diabetes had received a flu vaccination, compared to the national average of 90%.

The practice had a system for completing clinical audits and we saw four clinical audits that had been undertaken in the last year. The practice had used results from the audits to make changes in treatment therapies and prescribing practice. For example, a clinical audit had been undertaken to check that the practice was appropriately treating patients with diabetes, as prevalence compared to other practices within the local area appeared low. In this instance, we saw that changes had been made to administrative procedures within the practice, as inaccuracies in recording had been identified as a result of the audit.

GPs maintained records showing how they had evaluated the results from clinical audits and we saw records where actions had been discussed and agreed with regards to changes to specific treatments and therapies, in order to improve outcomes for patients.

Effective staffing

The practice staff team included GPs, nurses, managerial and administrative staff. We were told by staff that they had completed mandatory training in basic life support, infection control, and confidentiality and we saw records

that confirmed this. We saw that nurses had also completed specialist clinical training appropriate to their role, for example, diabetes, asthma, COPD and updates in childhood immunisations.

We were told by staff that they received annual appraisals and informal supervision. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. We saw records that confirmed annual appraisals had been undertaken for all staff in the last year. A process for GP appraisal and revalidation was in place and we saw that dates were confirmed for annual appraisal and completion of revalidation for each GP within the practice.

Nursing staff we spoke with confirmed that the practice was proactive in providing training and clinical support for their roles. For example, nursing staff who had prescribing responsibilities were monitored and supported by the medicines management lead within the clinical commissioning group and practice nurses attended regular meetings with the local area practice nurse group.

Working with colleagues and other services

We were told by GPs and nurses that the practice had well established processes in place for multi-disciplinary working with other health care professionals and partner agencies. They told us that these processes ensured that links remained effective with health visitors, community and specialist nurses, to promote patient care, welfare and safety. For example, mothers and new babies were referred to the health visitor, who held two clinics each month at the practice. GPs and nurses attended multidisciplinary meetings that included community nurses, social services and the palliative care team who had specialist knowledge in long-term and complex conditions. Follow-up actions from the meetings were recorded directly into patients' electronic notes by administrative staff attending the meetings.

We were told by administrative staff that systems were in place to process urgent referrals to other care / treatment services and to ensure that test results and notifications were reviewed in a timely manner once they had been received by the practice. They described the system they used to check test results and clinical information on a daily basis and how the information was shared promptly with GPs and nursing staff as a priority. The GP seeing these documents and results was responsible for the action required. Information from the 'out of hours' service was collated and distributed to GPs in the same way, with protocols in place for administrative staff to update patient information into the electronic records system. All the staff we spoke with understood their roles and felt the system worked well.

Information sharing

Staff told us that there were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, there was a system to monitor patients' transition in relation to unplanned / emergency admissions to hospital. The practice received discharge notifications and these were followed-up by GPs to review and plan on-going care / treatment where required. A referral system was used to liaise with the community nurses and other health care professionals, for example, the community learning disability nurse.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future use.

All staff told us that the practice held regular staff meetings to help ensure they were up-to-date with appropriate and relevant information, for example, clinical meetings, significant event meetings, governance / management meetings and administrative staff meetings. We were told that not all practice meetings were recorded although regular discussions were held with staff within the practice. We saw that the bi-monthly governance / management meetings were formerly recorded and we saw a selection of meeting notes from the general administration staff meetings.

Consent to care and treatment

The practice had a policy in relation to consent to examinations and treatment and included guidelines for staff to follow. A process was in place to ensure patient consent was recorded in the electronic patient records. Staff we spoke with gave examples of the process they would follow if a patient was unable to give consent, for example, they would refer to the GP.

Good

Are services effective?

(for example, treatment is effective)

Staff told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records would indicate whether a carer or advocate was available to attend appointments with patients who required additional support.

Nurses and GPs demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Some staff told us that they had undertaken formal Mental Capacity Act training and we saw records that confirmed this.

Health promotion and prevention

Staff told us about the process for informing patients that needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us that they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation. Information about how to access other health care services was also displayed to help patients access the services they needed. For example, patients were able to access the mobile diabetic eye screening service that was held at the practice on a regular basis.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening and general health checks including weight and blood pressure monitoring. We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and identify any concerns or risk factors that would then be referred to the GPs.

The practice had systems to identify patients who required additional support and were pro-active in offering additional help. For example, vaccination clinics were promoted and held at the practice, including a seasonal flu vaccination for older people. The practice kept a register of patients who had a learning disability and promoted / encouraged annual health checks for these patients.

The practice offered a full range of immunisations for children and travel vaccines. Last year's performance for childhood immunisations was either in line or above average for the CCG area and there were systems in place to follow-up non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, as well as a survey of patients undertaken by the practice's patient participation group. The evidence from these sources showed patients were satisfied with the service they received. For example, data from the national patient survey showed the practice was rated above average for patients rating the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with GPs and nurses, patients said they were treated with care and concern.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 20 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect and only one comment was less positive. We also spoke with 9 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. From our observations, we saw that reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests.

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

We were told by staff that the practice had a confidentiality policy, which detailed how staff should protect patients' confidentiality and personal information. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and we saw that the policy had been shared with them. Staff told us that an additional telephone line had been introduced so that calls could be taken in the rear office behind the reception area, to maintain confidentiality when speaking to patients on the telephone.

We were told by staff that the practice had a chaperone policy in place that set out the arrangements for patients who wished to have a member of staff present during clinical examinations or treatment. Records showed that most staff had received up-to-date chaperone training. We saw notices informing patients that they could ask for a chaperone to be present during their consultation if they wished to have one.

The practice had arrangements to provide additional support for patients whose circumstances may have made them vulnerable. For example, home visits would be arranged for vulnerable patients who might be reluctant or unable to attend the practice.

Care planning and involvement in decisions about care and treatment

Patients were involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. Patients we spoke with said they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment, that GPs and nurses took the time to listen and explained all the treatment options available to them. They said they felt able to ask questions if they had any and were able to change their mind about treatment options if they wanted to.

The patient survey information we reviewed showed patients responded positively to questions in relation to their involvement in planning and making decisions about their care and generally rated the practice well in these areas. For example, data from the national patient survey showed that 92% of patients said GPs were good or very good in involving them in decisions about their care, compared to 81% nationally. Similarly, 90% of patients said nurses were good or very good at involving them in decisions about their care, compared to 85% nationally. The QOF data we reviewed showed that, of those patients who had a care plan, 100% had been agreed between the patient and their family / carer, compared to 87% nationally.

Good

Are services caring?

We saw a range of leaflets and posters in the waiting room to provide patients with information about health care services. For example, information about the practice and the services it offered, the promotion of healthy lifestyle choices and contact details of other services and support that patients may have found useful. Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the support they needed and that they felt able to discuss any concerns or worries they had.

We saw that patient information leaflets, posters and notices were displayed that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, a counselling / bereavement support group. The practice's electronic system alerted GPs if a patient was also a carer. We saw a range of information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was responsive to patients' needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and that there were systems in place to refer patients to other services and support if required.

The practice engaged with the clinical commissioning group and told us that there was a lead GP within the practice who attended meetings on a regular basis. Information was exchanged and the practice GPs were kept aware of service developments and requirements for the locality.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice had developed an improvement plan as a direct result of the findings from the most recent patient survey undertaken by the PPG. We saw that this included plans to improve communication and awareness for patients in understanding the different ways of accessing appointments and services at the practice. For example, email contact and increased use of the practice website, to include the introduction of online facilities for repeat prescription ordering and making appointments. We saw that this had been implemented and some of the patients we spoke with were using these facilities.

Tackling inequity and promoting equality

We saw that the waiting area was large enough to accommodate patients with wheelchairs and there was an area at the entrance to accommodate prams. There was easy access to the treatment and consultation rooms that were all located on the ground floor. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had a hearing loop system for patients who had hearing difficulties and interpretation services were available by arrangement for patients who did not speak English.

The practice took account of the needs of different patients in promoting equality and considered those who may be in vulnerable circumstances. For example, working closely with the community learning disability nurse to ensure those patients with a learning disability received appropriate support and an annual assessment of their health care needs.

Access to the service

Appointments were available from 8.30am to 6.30pm each week day, excluding lunch-time when the surgery was closed. The practice operated extended opening hours until 8pm on Monday and Wednesday evenings, which provided flexibility for working patients outside of core working hours. Staff we spoke with were all knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs.

We found patients could book an appointment by telephone, online or in person. All patients we spoke with said that the appointments system worked well for them. Patients told us that they could have telephone consultations and that the GPs were very good at calling them back if requested. The GPs we spoke with confirmed that same day telephone consultations were offered to all patients and this was managed via the electronic communication system.

Patients we spoke with and comments we received all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and staff would know how to prioritise appointments for them. For example, the practice had a system to identify and prioritise patients with mental health needs to ensure urgent access to a GP appointment and referral to specialist mental health support if required. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment, if they needed an appointment or how the GPs would decide to support them in other ways, for example, a telephone consultation or home visit. The practice also offered pre-bookable appointments and online appointment bookings. Patients also told us they could always request longer appointments if they needed them. There was a system for patients to obtain repeat prescriptions and when we spoke with patients, they told us that they found the system worked well and their medicines were available when they needed them.

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the out of hours service was

Good

Are services responsive to people's needs?

(for example, to feedback?)

displayed inside and outside the practice and was also included in the patient information booklet. A telephone message informed patients what to do if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice had a complaints policy that was in line with recognised NHS guidance and there was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system; the procedure was displayed in the patient waiting area, there was a complaints leaflet and details were also included in the practice information booklet. We looked at two complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way.

We saw that a complaints summary report had been produced for the year, to identify any emerging themes or trends and was discussed at practice meetings to review any changes that could be made and we saw that these were acted on. For example, a new administrative system had been implemented to improve email communication from patients requesting their repeat prescriptions.

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to make a complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a 'mission statement' and a 'patient charter' that set out the aims, objectives and purpose of the practice. We spoke with a partner GP who told us that the practice worked towards a strategy, based on a 'team' approach in providing good quality care and treatment for patients. When speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients.

Governance arrangements

The governance arrangements within the practice included the delegation of responsibilities to named GPs, for example, a lead for safeguarding, dispensing and prescribing, and a lead for engagement with the CCG. This helped to clarify the role of each GP and provided structure for staff in knowing who to approach for support and clinical guidance. We spoke with nine members of staff and they were all clear about their roles and responsibilities and who to go to if they had any concerns or issues.

We saw that the practice had a schedule of meeting dates arranged for the year and this included practice meetings, clinical meetings and administration staff meetings. We saw minutes from the quarterly practice meetings and we were told that regular clinical meetings took place between the practice nursing staff and the GPs, although these were not minuted. We saw the minutes from administration staff meetings and these included discussions about systems, processes and learning points from incidents and general matters relating to patient records and administrative activities.

The practice used information to monitor the quality of the services it provided. For example, clinical audits had been completed and we saw that data from the Quality and Outcomes Framework (QOF) indicated that the practice was performing at or above national standards in most areas. However, there were no arrangements to ensure audits were routinely completed to monitor the safety of the services provided. We were told that no infection control audits were undertaken and there were no records of general health and safety checks of the premises. There were no staff training audits to monitor the training completed for GPs, nurses and administrative staff and the practice did not have a system to check and ensure that professional registrations were kept up-to-date for GPs and nurses.

The practice did not have a system for identifying, assessing and managing risks within the practice. We were told that the practice did not have a risk log or register to record how risks were monitored and we saw only one risk assessment for the premises that had not been reviewed or updated since 2007. There were no records to show that risks were routinely discussed at practice meetings.

The practice had a range of policies and procedures to govern activity and these were available to staff via the desktop on any computer within the practice. Staff we spoke with told us they were aware of the policies and knew where to find them for guidance. We reviewed a number of policies, for example, recruitment of staff, complaints and the safeguarding policy and saw that these were in date.

Leadership, openness and transparency

We spoke with GPs who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. There was a leadership structure within the practice, with named members of staff in lead roles, although we were told that changes within the partnership were planned. However, it was not clear whether a review of the leadership arrangements had been discussed and considered amongst the partners in relation to succession planning for the future.

All the staff we spoke with told us that they felt there was an 'open door' culture, that the GPs were approachable, and that they felt supported and were able to approach the senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well and that staff meetings were held regularly. All staff said that they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

The practice manager was responsible for human resource policies and procedures. We saw a number of procedures

Are services well-led?

Requires improvement

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

that were in place to support staff, for example, disciplinary, grievance and sickness management procedures and these were included in the electronic staff handbook that was available to all staff.

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

The practice had gathered feedback from patients through patient surveys undertaken by the practice participation group and complaints they had received. We were shown a report on comments and complaints received from patients, as well as an improvement report collated from the comments received from the patient survey for 2014. Where common themes were identified, the practice had responded by making improvements and changes wherever possible, For example, we saw that some staff had received additional customer care training as a result of comments received.

The practice patient participation group was well established and had plans to increase its membership to include 'virtual' online members. They met bi-monthly and had carried out annual surveys. The practice manager showed us the analysis of the most recent survey, and the improvements that had been agreed based on the findings, for example, an online facility for patients to make appointments and order repeat prescriptions.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they would be confident and feel supported to give feedback and discuss any concerns or issues with colleagues and management. They also described some of the suggestions they had made to make improvements for patients, for example, an additional telephone in the office behind the reception area to help improve confidentiality and we saw this had been acted on. Staff said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle-blowing policy which was included in the staff handbook and was available to all staff electronically on any computer within the practice. Staff we spoke with told us they knew where to find the policy / guidance and would use the process if necessary.

Management lead through learning and improvement

Records showed that GPs and nursing staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. We saw that appraisals were undertaken for all staff, to review performance and personal objectives.

We saw that there was a system to ensure that GPs received an annual appraisal and the GP revalidation process had been implemented at the practice.

The practice had completed reviews of significant events and other incidents and shared them with staff during meetings. For example, recent incidents had led to improvements in administration processes used in the practice.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the regulation was not being met:** People who used the services were not protected against the risks associated with the unsafe management of medicines because the provider had not ensured that staff who administered vaccines were authorised to do so under patient specific directions, in line with legal requirements and national guidelines. The provider had not ensured that all staff who administered vaccines were appropriately trained to do so. **Regulation 13**

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:** Patients who used the practice and others were not protected against the risks associated with the recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain and record sufficient information about the staff they employed, such as photographic identification, references and employment history checks - as required under Schedule 3 of the HSCA 2008. **Regulation 21(b)(c)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Compliance actions

Surgical procedures

Treatment of disease, disorder or injury

How the regulation was not being met:

Patients who used the practice and others were not protected against the risks of receiving inappropriate or unsafe care and treatment, because the provider did not have effective systems to regularly assess and monitor the quality and safety of the service, as there was no evidence of on-going, regularly completed infection control audits, premises checks, including legionella, and training audits. There was no evidence that the provider had a robust process in place for identifying, assessing and managing all risks.

Regulation 10 (1)(a)(b)