Laburnum Surgery

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 Laburnum Surgery on 16 July 2015. Specifically, we found the practice to require improvement for providing safe and responsive services and for being well led. They were rated as good for providing effective and caring services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was a system in place for reporting, recording and monitoring significant events.
- Some risks to patients and staff were not assessed and systems and processes were not fully implemented to keep patients safe. For example, the practice did not follow its recruitment policy. Some staff had not undergone recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. We saw a system of clinical audit to improve outcomes for patients. However, child immunisation rates were significantly lower than the clinical commissioning group (CCG) averages for some groups.
- Staff had received training appropriate to their roles. There was an appraisal system in place.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Data showed that patients rated the practice lower or in line with the CCG averages for being caring.
- Most patients we spoke with and those who completed CQC comment cards indicated they felt they could obtain appointments, including urgent appointments, when needed.
- The practice had a system in place for handling complaints and concerns; however this was not fully developed.

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- The practice proactively sought feedback from patients and conducted an annual patient satisfaction survey.
- There was a vision and a strategy for the future and a leadership structure and staff felt supported by management. However, some of the systems and processes which should have been in place to keep patients and staff safe were not in place.

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

Importantly, the provider must:

- Ensure recruitment procedures are established and that they operate effectively.

In addition the provider should:

- Improve the way staff training is recorded.
- Carry out infection control training for staff.
- Improve the way complaints are investigated and responded to.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where they must make improvements.

The practice had a recruitment policy in place, however this was not followed. There were two nurses employed at the practice and relevant recruitment checks had not been completed.

However, systems and processes to address health and safety risks were implemented to ensure patients were kept safe. There was a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used opportunities to learn from incidents to support improvement. The practice had regular multidisciplinary meetings to discuss the safeguarding of vulnerable patients.

Are services effective?

Good

The practice is rated as good for providing effective services.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. We saw the practice had achieved a score of 97% of the percentage points available to them for providing recommended treatments for the most commonly found clinical conditions. This was below the local clinical commissioning group (CCG) by 0.6 percentage points and above the England average by 3.1 percentage points. Patients' needs were assessed and care and treatment was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice had systems in place for completing clinical audit cycles to review and improve patient care. Staff had received training appropriate to their roles. There was evidence of appraisals for all staff except the practice manager.

However almost all of the previous year's child immunisation rates were below the CCG averages. The practice told us they had disputed this with NHS England and provided data with improved figures.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice above or just below the national averages for being caring. Patients told us that they were treated with compassion, dignity and respect and were involved in

Summary of findings

decisions about their care and treatment. Information to help patients understand services available was easy to understand. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services as there are areas where they should make improvements.

The practice had a system in place for handling complaints and concerns; however this was not fully developed.

However the practice knew the needs of their practice population. Most patients said they found it easy to make an appointment, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services as there are areas where they should make improvements.

They had a vision and a strategy for the future and knew how they wanted to improve the services they provided. However, there was no review dates to monitor progress. The practice had policies and procedures to govern activity; however these were not always followed. There was a leadership structure and staff felt supported by management. There was a system of clinical audit in place to improve patient outcomes. Regular staff meetings were held. The practice proactively sought feedback from patients.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. There are aspects of the practice that require improvement and therefore this impacts on all population groups.

All patients aged over 75 had been notified of their named GP. High risk groups of elderly patients, such as those receiving palliative care had comprehensive care plans in place. The practice had a nursing home in their area where one of the lead GPs visited every week. The elderly were offered the pneumococcal and flu vaccine. The district nurse carried out home visits to patients who were unable to attend the surgery during the winter flu vaccine season and was able to administer the vaccine if appropriate.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. There are aspects of the practice that require improvement and therefore this impacts on all population groups.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients were seen during the practice nurse's clinics, with the GPs input where necessary. The practice nurse managed the long-term condition register. Medication reviews were usually carried out during the nurse prescriber clinics on a Saturday morning. There were examples of comprehensive care plans in place for patients with complex needs, in particular, those at high risk of hospital admission and those receiving palliative care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There are aspects of the practice that require improvement and therefore this impacts on all population groups.

The practice held ante-natal clinics which were ran by the midwife. There was no set baby clinic; the practice found it was more useful for patients to make an appointment with the practice nurse at a time which was suitable to them. A full range of immunisations for children, in line with current national guidance were offered. However almost all of the previous year's child immunisation rates were below the CCG averages. For example, vaccination rates for children at 12 months were all 48%. The CCG averages ranged between 84.7% and 96.3%. However the practice manager told us

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they had queried this with NHS England as they believed the rates to be higher. Following our inspection the practice provided us with further information on child vaccination rates. For example, for the meningitis C vaccine at 24 months practice records showed 88% (28 of 32 children) had received the vaccine. Data published by NHS England showed 78.1% of children had received the vaccine.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). There are aspects of the practice that require improvement and therefore this impacts on all population groups.

The needs of the working age population (including those recently retired and students) had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. There were appointments available with the nurse prescriber on alternate Saturday mornings. The practice offered telephone consultations. There was on-line access available to book appointments and order repeat prescriptions.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. There are aspects of the practice that require improvement and therefore this impacts on all population groups.

The practice had a learning disability register but they recognised it was not very accurate. They were in the process of updating their records and asking this group of patients to attend for a review. All patients with a learning disability had a named GP. The practice told us they had higher numbers of patients who were experiencing substance or drugs misuse. They said they felt they were more tolerant than other practices when these groups of patients missed appointments. Patients were signposted to the substance misuse team. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). There are aspects of the practice that require improvement and therefore this impacts on all population groups.

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There were examples of comprehensive care plans in place for patients with complex mental health needs. The practice had a register for those experiencing poor mental health and they had a named GP. Patients were invited to the practice for an annual review. Patients experiencing severe poor mental health who required support received short term prescriptions so that the GP could monitor their progress when they attended for their medication review. One of the GPs told us they provided significant personalised counselling.

The practice were aware that dementia was an area in which they should make improvements. For example, the number of patients diagnosed with dementia who had received a review in the last twelve months was 66.7%, the CCG average was 81.7% and the England average 77.9%.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection.

All of the patients we spoke with were satisfied with the care they received from the practice. They told us staff were friendly and helpful. Most patients said they were supported and listened to in their appointments. Patients said occasionally it could be difficult to obtain an appointment but on the whole they were satisfied with the appointment system.

We reviewed 12 CQC comment cards completed by patients prior to the inspection. The cards provided positive feedback on the level of care, comments included very good and excellent. Patients said the surgery was always clean. Feedback on access to appointments was mixed. Two patients commented that sometimes obtaining an appointment could be difficult. On two of the comment cards patients said they had always been able to obtain a same day appointment for children when they had contacted the surgery.

The latest GP Patient Survey published in January 2015 showed most patients were satisfied with the services the practice offered. Patients who described their overall experience as good was 78%, which was below the local clinical commisioning group (CCG) average of 87% and the national average of 85%. Other results were above and below the national averages:

- GP Patient Survey score for opening hours – 78% (national average 75%);
- Percentage of patients who were able to get an appointment to see or speak to someone the last time they tried - 90% (national average 85%);
- Percentage of patients who find it easy to get through to this surgery by phone - 74% (national average 73%);
- Percentage of patients who find the receptionists at this surgery helpful - 95% (national average 87%);
- The proportion of patients who would recommend their GP surgery – 66% (national average 78%).

These results were based on 111 surveys that were returned from a total of 317 sent out; a response rate of 35%.

The practice carried out its own survey in 2014. 78 responses were received, the feedback was;

- 79% of patients were satisfied with the practice overall;
- 82% of patients said they were treated good, very good or excellent by the receptionists;
- 92% of patients said they had seen a doctor within three working days, 47% the same or next working day for a routine appointment.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment procedures are established and that they operate effectively.

Action the service SHOULD take to improve

- Improve the way staff training is recorded.
- Carry out infection control training for staff.
- Improve the way complaints are investigated and responded to.

Laburnum 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 and a specialist advisor with experience of GP practice management.

Background to Laburnum Surgery

The area covered by Laburnum Surgery is predominantly Ashington and the surrounding villages. The practice provides services from the following address and this is where we carried out the inspection, Laburnum Medical Group, 14 Laburnum Terrace, Ashington, Northumberland, NE63 0XX.

The surgery is located on a main street in a row of shops and has been established for over 100 years. Modifications have been made to the premises, it has an automatic door for wheelchair access and patient services are on the ground floor.

The practice has two GPs partners, who work part-time, one male and one female. There are two practice nurses and one nurse practitioner who work part-time. There is a practice manager and there are four administrative staff which includes a secretary and three receptionists.

The practice provides services to approximately 2,200 patients of all ages. The practice is commissioned to provide services within a Personal Medical Services (PMS) agreement with NHS England.

The index of multiple deprivation (IMD) placed the practice as band two for deprivation, where one is the highest deprived area and ten is the least deprived.

The practice was open Monday to Friday 9am to 6:30pm. There is a nurse practitioner led surgery for pre-booked appointments two Saturday mornings a month. Patients were able to book appointments either on the telephone, at the front desk or using the on-line system.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

We inspected this service as part of our 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 registered 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.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

We carried out an announced visit on 16 July 2015. During our visit we spoke with staff. This included one of the GP partners, a practice nurse and reception and administrative staff. We also spoke with five patients. We reviewed 12 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

As part of our planning we looked at a range of information available about the practice from the National GP patient survey and the Quality Outcomes Framework (QOF), which is a national performance measurement tool. The latest information available to us indicated there were some areas of risk in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. For example, an event was raised as a good example of a patient who required palliative patient care. They were identified by the GP and communication was set up between the family, GP and secondary care and the patient's wishes were taken into account.

Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records, incident reports and minutes of meetings. These showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Systems and processes to address health and safety risks were implemented to ensure patients were kept safe. However, the practice did not follow their recruitment procedures, for example, checks on medical indemnity insurance. The practice could therefore not demonstrate a consistent safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. They were open and transparent when there were near misses or when things went wrong. There were records of significant events and we were able to review these. The points recorded were, what happened, the key issues, areas of concern and suggestions to prevent re-occurrence. The lead GP told us staff would inform them or the other GP partner if a significant event was raised.

The lead GP and practice manager told us that ad hoc meetings would be called to discuss a significant event if one was raised. They reviewed the events annually to identify any patterns or trends. We saw minutes of staff meetings where significant events were discussed.

National patient safety alerts came to the practice via a generic email. The practice manager had responsibility to disseminate the alerts to the GPs. They were printed off and placed in a folder, the GP signed when they had seen and read the alert and the practice manager monitored this.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They met with health visitors and the school nurse on a monthly basis to discuss safeguarding issues. The practice had a dedicated GP as the lead for both safeguarding vulnerable adults and children. There was a safeguarding children and vulnerable adult's policy. Staff we spoke with were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

Staff told us they had been trained to the appropriate level for child safeguarding. We saw training certificates showing that staff were trained to the appropriate level for safeguarding children. Safeguarding adults training, including domestic violence awareness training had been held at the practice in 2013.

The practice had a chaperone policy. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone. Staff we spoke with told us that the practice nurses acted as chaperone if required, a double appointment with the GP and practice nurse would be booked.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, this described the action to take in the event of a potential failure. Stock control of medicines was managed by the practice nurse. Processes were in place to check medicines were within their expiry date and

suitable for use. This system was not always effective, for example, medicines we checked were within their expiry dates except for one box which was disposed of immediately. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that the patient's repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

We saw the practice was clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities.

We saw there was an up-to-date infection control policy and guidance for staff about specific issues such as needle stick injuries. One of the GP partners was the infection control lead. However, the practice manager had carried out the most recent infection control audit in January 2015. The last infection control training the staff had received was in 2012. We did not however see any documented evidence of training certificates for this training. The practice manager told us the practice had recently signed up to an on-line training company and infection control training was one of the modules the staff were to complete.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw a log book which contained the dates the disposable privacy curtains in the consultation rooms were changed every six months. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice employed their own cleaner. There were cleaning schedules in place for use by the cleaners.

An external contractor had carried out a legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessment.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments which was appropriate for patient's needs. The practice had a range of equipment in which included medicine fridges, patient couches, sharps boxes (for the safe disposal of needles) and fire extinguishers. We saw the practice had a policy for the calibration of equipment, a log book was held with each piece of equipment listed and the date it was last tested. We saw stickers on the equipment which verified testing had taken place in the last year. Portable electrical equipment had been tested in January 2015.

Staffing and recruitment

We saw the practice had a recruitment policy which had been updated in the last year. However the practice did not follow the policy. For example, there were no checks to ensure clinical staff's professional registration, such as General Medical Council (GMC) for GPs and Nursing and Midwifery Council (NMC) for nurses were up to date.

There were three nurses employed at the practice. One practice nurse had a contract of employment, references and a disclosure and barring service (DBS) check in place. The other practice nurse and nurse practitioner did not have any recruitment documentation in place other than a DBS check from another employer which is not transferable. We were told they had both worked part time at the practice for some years and they also worked at other practices where it was assumed the correct recruitment checks and training had been carried out.

We looked at the recruitment files of administration staff and saw, checks had been carried out such as references and contracts were in place. The staff had NHS SMARTcards therefore proof of identity would have been previously sought. There were no checks on evidence of legal requirement to work in the UK which was stated as an action required in the practice's recruitment policy.

There was no documented risk assessment for non-clinical staff who had been employed prior to April 2013 as to why they had not received a DBS check. The practice manager said they knew the rationale as to why they had not carried these out but had not formally documented this and would carry this out as soon as possible.

There were no regular checks of medical indemnity insurance for clinicians employed at the practice. However,

Requires improvement

Are services safe?

on the day of the inspection we were able to see one of the GPs certificates which they held and after the inspection copies of other clinicians certificates were forwarded to us, which were up to date.

The practice manager told us it was relatively easy to plan and monitor the number of staff and mix of staff needed to meet patients' needs due to the practice being small. Locums had not been used at the practice for some years; the GPs covered each other's absences.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and a risk assessment. There was a log of all substances hazardous to health in the practice (COSHH).

The practice manager showed us the fire risk assessment which had been carried out and updated in the last year. Staff received fire training and updates every year from the fire service. There were training certificates to confirm this. One of the GP partners was the nominated fire warden. We saw records confirming the fire alarms and emergency lights were regularly tested. However, staff told us and the practice manager confirmed there had been no fire evacuation drill for over 12 months.

The practice had developed lines of accountability for all aspects of patient care and treatment. Both GPs and had lead roles such as palliative care and safeguarding for clinical issues and non-clinical responsibilities such as health and safety and information governance.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with regarding emergency procedures knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The defibrillator and oxygen were accessible and records of weekly checks were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plans were held by the practice manager and GPs at their homes and contact details were available if the buildings were not accessible.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and practice nurse we spoke with could outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE). There were regular audits carried out and internal peer review on referrals to hospital between the GPs.

We found from our discussions with the GP that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. There were examples of comprehensive care plans in place for patients with complex needs, in particular, those at high risk of hospital admission and those receiving palliative care. Patients with complex mental health needs had a care plan in place.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients were reviewed during the practice nurse's clinics, with the GPs input where necessary. The practice nurse managed the long-term condition register. Medication reviews usually carried out during the nurse prescriber clinics on a Saturday morning.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. 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 the practice had achieved a score of 97% of the percentage points available to them for providing recommended treatments for the most commonly found clinical conditions. This was below the local clinical commissioning group (CCG) by 0.6 percentage points and above the England average by 3.1 percentage points.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and practice nurse showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of a patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had a system in place for clinical audit. We saw that clinical staff were actively involved in audit and re-audit cycles. We saw four audits which had been carried out in the last year.

The practice had a higher than average rate of anti-biotic prescribing. They carried out two audits on the cause of this and had an action plan in place to address this issue. In one audit the second cycle showed there had been a reduction in antibiotic prescribing of 22% from November 2014 to February 2015.

The practice were below some of the CCG and England average percentage points on QOF. They told us they were aware of the areas where they should make improvement. For example, the number of patients diagnosed with dementia who had received a review in the last twelve months was 66.7%, the CCG average was 81.7% and the England average 77.9%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. There was a staff training record made available to us which set out training which staff should have and to what level. There was not, however, any central record which identified which training staff had undertaken and when remedial training was due.

We reviewed staff training records we saw staff had received training such as basic life support, fire safety, safeguarding children and adults and information governance. The last infection control training the staff had received was in 2012. We did not however see any documented evidence of training certificates for this

Good

Are services effective?

(for example, treatment is effective)

training. One of the practice nurses had received training for their role such as immunisations and contraception and heart failure. There were no training records for two of the nurses employed at the practice.

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

We saw evidence of yearly staff appraisals from the staff files we looked at. However, the practice manager was overdue their appraisal, the last one they had received was in 2013. The practice nurse we spoke with said they received clinical supervision from both GPs.

Working with colleagues and other services

The practice could demonstrate that they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held multidisciplinary team meetings. There were meetings which covered unplanned hospital admissions, safeguarding, and palliative care. These meetings were attended by the practice's GPs along with district nurses, social workers, community psychiatric nurses, drug and alcohol workers and palliative care nurses depending upon the meeting.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the NHS 111 service, were received both electronically and by post.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals 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 and patients welcomed the ability to choose their own appointment dates and times.

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

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent.

The GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA) on a patient by patient basis. We found the GP was aware of the MCA and used it appropriately and told us they had received MCA training. The GP described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GP told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

New patients were able to collect a registration form from the reception area. Patients could also collect a pre-registration form from the surgery. The patient was

Good

Are services effective?

(for example, treatment is effective)

then required to complete a medical questionnaire. All patients were offered a new patient health check with the practice nurse who, wherever necessary could refer the patient to a GP.

Information on a range of topics and health promotion literature was available to patients in the waiting area. Information available included chronic heart failure management and information on the local carers association. Patients were encouraged to take an interest in their health and take action to improve and maintain it.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's used clerical registers to facilitate this. QOF data confirmed, for example, the practice had achieved 100% of the percentage points available for the clinical indicator of hypertension which was 7 percentage points above the CCG average and 11.6 above the England average. For the indicator of diabetes the practice achieved 92.2% of the percentage points available which was 2.6 points below the CCG average and 2.1 above the England average.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages. The percentage of women between the age of 25 and 64 with a record of cervical screening was 73.5% which was below the CCG average of 79.9% and the England average of 76.9%.

The practice held ante-natal clinics which were ran by the midwife. There was no set baby clinic; the practice found it was more useful for patients to make an appointment with the practice nurse at a time which was suitable to them. A full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance were offered.

Almost all of the previous year's child immunisation rates were below the CCG averages. For example, vaccination rates for children at 12 months were all 48%. The CCG averages ranged between 84.7% and 96.3%. However the practice manager told us they had queried this with the CCG as they believed the rates to be higher. One of the lead GPs told us the practice used to have a health visitor attached to the practice who had been very good at following up children to attend for their vaccinations and they had now retired. We were shown a clerical recall book which the practice nurse used to recall children for vaccinations.

Following our inspection the practice provided us with further information on child vaccination rates. For example, for the meningitis c vaccine at 24 months practice records showed 88% (28 of 32 children) had received the vaccine. Data published by NHS England showed 78.1% of children had received the vaccine.

The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 76%; the national average was 73%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with five patients on the day of our inspection. All of the patients we spoke with were satisfied with the care they received from the practice. They told us staff were friendly and helpful. Most patients said they were supported and listened too in their appointments. We reviewed 12 CQC comment cards completed by patients prior to the inspection. The cards provided positive feedback on the level of care, comments included very good and excellent.

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey (January 2015). Results were below the local clinical commisioning group (CCG) averages. For example, the proportion of patients who described their overall experience of the GP surgery as good was 78%, which was below the local CCG average of 87% and the national average of 85%.

The proportion of patients who said their GP was good or very good at treating them with care and concern was 77%, the CCG average was 88%. The proportion of patients who said the nurse was good or very good at treating them with care and concern was 91%, the CCG average was 93%. The practice carried out its own survey in 2014, 86% of patients scored the GPs as good or very good at treating them with care and concern.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. The GP national survey data showed 95% of patients found the receptionists helpful; the CCG average was 89%. The practice's own survey showed that 82% of patients said they were treated good, very good or excellent by the receptionists;

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. The practice manager carried out regular in-house spot checks of information governance.

Care planning and involvement in decisions about care and treatment

Patients told us they felt listened to by the GPs and practice nurses. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

From the 2015 National GP Patient Survey, 75% of patients said the GP they visited had been good at involving them in decisions about their care (CCG average was 86%). The data showed that 82% of patients said the practice nurse they visited had been good at involving them in decisions about their care (CCG average 87%).

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

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice's computer system alerted GPs if a patient was also a carer. There was support available for carers from the local carer's support group.

There was a palliative care register and regular contact with the district nurses. There were monthly palliative care meetings which involved GPs, district nurses and palliative care nurses.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. Patients we spoke with said they felt the practice was meeting their needs. The practice had been established for over 100 years in the same location and both GPs had worked there for a number of years. They prided themselves on being a small family practice who knew their patients by name and provided continuity of care. The practice were aware they could not provide some of the facilities a larger practice could, however they were flexible in their approach to their patients. For example, staying later beyond closing time to see a patient who could not make normal opening hours or visiting them at home.

All patients aged over 75 had been notified of their named GP. High risk groups of elderly patients, such as those receiving palliative care had care plans in place. The practice had a nursing home in their area where one of the lead GPs visited every week.

The practice had a learning disability register but they recognised it was not very accurate; they were in the process of updating their records and asking this group of patients to attend for a review. All patients with a learning disability had a named GP.

The practice had a register for those patients experiencing poor mental health and they had a named GP. Patients were invited to the practice for an annual review. Patients experiencing severe poor mental health, who required support, received short term prescriptions so that the GP could monitor their progress when they attended for their medication review. One of the GPs told us they provided significant personalised counselling to this group of patients.

The practice told us they had higher numbers of patients who were experiencing substance or drugs misuse. They said they felt they were more tolerant than other practices when these groups of patients missed appointments. Patients were signposted to the substance misuse team.

The practice told us they had tried to introduce a patient participation group (PPG) but experienced difficulty in patients coming forward to join. They had put up posters in the waiting area, advertised it in the pharmacy next door to the practice and put messages on prescriptions. The practice gained the views of the patients by carrying out an annual in house survey. Feedback from the survey had influenced changes in telephone advice which was available to patients. There was also a suggestion box in the waiting area. On the day of our inspection a member of staff from Healthwatch, which is the consumer champion for health and social care, was visiting the practice to help make suggestions regarding a PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services, including sign language, if required.

All of the treatment and consulting rooms were on the ground floor and could be accessed by those with mobility difficulties. There was an electronic front door and the reception desk was lowered for access of those patients in a wheelchair. The disabled patient toilet was on the first floor and there was a stair lift in place.

There was no patient or staff parking outside of the surgery it faced onto a pedestrianised part of a main road. There was parking in the surrounding streets.

The practice had a male and female GP, which gave patients the ability to choose to see a male or female GP.

Access to the service

Patients we spoke with said occasionally it could be difficult to obtain an appointment but on the whole they were satisfied with the appointment system. From the CQC comment cards completed feedback on access to appointments was mixed. Two patients commented that sometimes obtaining an appointment could be difficult. On two of the comment cards patients said they had always been able to obtain a same day appointment for children when they had contacted the surgery.

The National GP Patient Survey 2015 showed patient satisfaction was in line with the local averages, 75% of patients said their overall experience of making an appointment was very good or fairly good (CCG average 76%). From the practice's own survey in 2014, 92% of patients said they had seen a doctor within three working days, 47% the same or next working day for a routine appointment.

The practice was open Monday to Friday 9am to 6:30pm. There was a nurse prescriber led surgery for pre-booked appointments two Saturday mornings a month. Patients

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

were able to book appointments either on the telephone, at the front desk or using the on-line system, there were appointments to book in advance and emergency appointments were released at 9am and 3:30pm.

One of the GP partners and practice manager explained that they had a flexible approach to appointments due to the practice being small. GPs would occasionally stay back after closing or even visit patients at home to suit their needs. Children and the elderly and frail were always seen on the same day.

We looked at the practice's appointments system in real-time on the day of the inspection. At that time the next routine bookable appointment was the following Monday which was two working days away. However there was a longer wait for a routine appointment with the practice nurse, whose next available appointment was eight working days away.

Information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice offered appointments and repeat prescriptions on-line. Repeat prescriptions could also be ordered via post or at reception.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns; however this was not fully developed. The complaints policy did not set out who was responsible for complaints at the practice. The complaints information leaflet did not specifically contain information regarding taking a complaint further than the practice, for example to NHS England or the parliamentary and health service ombudsman. It made reference to the Primary Care Trust (PCT) which was abolished in 2013. Following the inspection the practice manager emailed us and advised the complaints information had been updated.

The practice manager told us they handled all complaints in the practice. There had been seven complaints received in the last 12 months. Three of the complaints related to the attitude of one of the clinical members of staff. There was a lack of documented evidence of investigation into the complaints and content of the response letters were very similar. The letter again did not contain information about taking a complaint further than the practice.

The practice manager told us complaints were dealt with as and when was necessary. We did not see any evidence of an annual review of complaints to identify any patterns or trends.

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 business plan for 2015 included their aim to provide patient centred care with;

- Excellent GP (doctor and nurse led) health care.
- To work alongside patients to improve healthcare through a joint approach.
- To provide patients with adequate information to encourage participation in decision making in relation to treatment options.
- To support families and carers
- To provide appropriate training for both clinical and clerical staff.
- To promote a blame free friendly working environment for staff.

The GPs aimed to become members of the Royal College of General Practitioners (RCGP) and for the practice to achieve RCGP accreditation.

The practice development plan set out these aims, however, there were no review dates set to monitor progress in the areas identified. There were business meetings held every 6-8 weeks.

The practice told us they had identified areas where they should improve. They recognised they needed to recruit a health care assistant which would free up some extra time for the practice nurse. They planned to reintroduce smoking cessation clinics. There were plans to have a meeting every Wednesday to discuss service improvements, for example, their higher than average referral rate of patients to accident and emergency department and their higher than average antibiotic prescribing rate.

Governance arrangements

The governance arrangements did not always operate effectively. There were policies and procedures in place; however these were not always followed. For example, there were two nurses employed at the practice who had not been vetted. The last infection control training the staff had received was in 2012. Staff told us they knew where policies and procedures were kept, on the practice's shared computer drive and they knew how to access them.

The practice had a system in place for handling complaints and concerns; however this was not fully developed and there was no annual review of complaints to ensure learning took place.

The practice had a system in place for clinical audit. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The practice had achieved a score of 97% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was below the local Clinical Commissioning Group (CCG) by 0.6 percentage points and above the England average by 3.1 percentage points.

Almost all of the previous year's child immunisation rates were below the CCG averages. The practice told this they had disputed this with NHS England and provided us with data with improved figures.

Leadership, openness and transparency

There was a well-established management team with allocation of responsibilities. Staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Regular meetings, involving staff at all levels, were held. The practice manager showed us examples of minutes of the meetings which were held, for example, multi-disciplinary (MDT) and clinical meetings.

We found the practice learned from incidents and near misses. Significant events meetings were held where such issues were discussed.

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

The practice had gathered feedback from patients through patient surveys and comments received. The practice had struggled to establish a patient participation group (PPG). They had tried numerous ways to obtain support for a group including consultation with Heathwatch.

The practice gathered feedback from staff through staff meetings. Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. All but one member of staff had received a staff appraisal.

Are services well-led?

Requires improvement

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

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice had some management systems in place which enabled learning and improved performance.

Staff felt they were supported in this area and attended the monthly CCG protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The management team met when necessary to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person must ensure that person's employed for carrying out the regulated activity are of good character.** **Recruitment procedures must be established and operate effectively.** Regulation 19 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed. (1) (a), (2) (a)