Penn Manor Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Penn Manor Medical Centre on 5 May 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be inadequate in safe, and requires improvement for providing effective, responsive and well led services. It was rated good for providing caring and services. The concerns we identified in the safe, effective, responsive and well-led domains relate to everyone who uses the practice including the population groups. Therefore all the population groups we inspected were rated as requires improvement.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and reasonably well managed, with the exception of those relating to recruitment checks.
- Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients' needs were assessed and care was planned, although best practice guidance was not always followed. Staff had received training appropriate to their roles.
- Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients told us when they contacted the practice they could request to speak with their preferred GP for a telephone consultation. All patients were offered a telephone consultation and appointments were made as required. Same day appointments were available with the GP registrars.
- There was a clear leadership structure and staff felt supported by management.
- The practice did not proactively seek feedback from patients.

Summary of findings

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

Importantly, the provider must:

- Ensure that all necessary pre-employment checks are obtained and appropriate evidence kept on file.
- Ensure that Patient Group Directives (PGDs) are up to date and signed by both the GP and nursing staff.
- Ensure there are systems in place to assess, monitor and improve the quality and safety of the service. For example the use audits, risk assessments and surveys.

In addition the provider should:

- Ensure the methods used to review and disseminate learning from significant events and near misses are robust.
- Provide staff with up to date infection prevention and control training.
- Ensure all staff understand the Mental Capacity Act 2005 and implications for their practice.
- Review how confidentiality is maintained at the reception and prescription desks, by both staff and visitors to the practice.
- Promote the availability of interpreter services.
- Ensure all staff are aware of and can identify with the practice mission statement and values.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However systems were not in place to discuss and review actions from past significant events to support improvement. Staff were aware of the signs of abuse in older people, vulnerable adults and children but were less clear about their responsibilities. Not all of the Patient Group Directions in place to support nurses to administer medicines to groups of patients without individual prescriptions had been signed by either the GP, the nursing staff or both. There was no evidence to support that the necessary employment checks had been obtained before staff started their employment. The practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, although these had not been recorded in a risk log.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services and improvements must be made. Staff referred to guidance from National Institute for Health and Care Excellence although changes were not always implemented. Patient's needs were assessed and care was planned and delivered in line with current legislation. Health promotion and prevention was routinely and opportunistically offered to reduce risks to patients' health. Staff had received training appropriate to their roles, although a structured system to record training was not in place. Staff worked with multidisciplinary teams to support children and adults with complex needs.

We saw limited evidence to support that clinical audits were taking place or the results shared amongst the clinical staff team.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and generally maintained confidentiality. Information and support was available for patients who also had caring responsibilities.

Summary of findings

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services and improvements must be made. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice operated a telephone triage system for the majority of GP appointments. Patients told us they were satisfied with the system although didn't like waiting to be called back by the GP. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

There was an accessible complaints system and evidence which demonstrated that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well led and improvements must be made. Staff felt supported by management and a clear leadership structure was in place. They were aware of their roles and responsibilities. The practice mission statement and values was not well known amongst staff. Appropriate records were not always maintained in relation to the management of the service and regulated activities.

The systems in place for assessing and monitoring service provision were not always robust to ensure all risks were appropriately managed. The practice did not have systematic approach to learning and improvement. An ongoing audit programme to promote continuous improvements to patient care was not in place and regular governance meetings were not held.

The practice did not have a patient participation group (PPG) to seek patient feedback and improve the service and the last patient survey was undertaken in February / March 2013. A PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

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

Plans were in place to ensure that every patient over the age of 75 years had a named GP for direct contact. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice identified those patients most at risk of admission to hospital and developed and agreed care plans with these patients. It was responsive to the needs of older people and offered home visits and extended appointments as required. The practice identified if patients were also carers, and information about support groups was available in the waiting room.

The practice reviewed all 80 year old patients not seen at the practice in the previous 12 month period. Through this review process they identified 10 adults. They acted on the information and set up system alerts to review these patients on a regular basis.

People with long term conditions

Requires improvement

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

We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. Nursing staff were supported by a lead GP for each condition. Longer appointments and home visits were available when needed. All these patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Requires improvement

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

There were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Appointments were available outside of school hours and the premises were suitable for children and babies. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Family planning advice was provided by staff at the practice. We saw good examples of joint working with other health and social care professionals.

Working age people (including those recently retired and students)

Requires improvement

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended hours four evenings a week. The practice had started to offer all patients aged 40 to 75 years old without a long term condition a health check with the nursing team. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

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

We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence or refugees. The practice held a register of

Summary of findings

patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability.

Staff knew how to recognise signs of abuse in vulnerable adults and to speak with a GP if they had any concerns. Staff knew where to find the contact details for the relevant agencies but not all staff were familiar with the process of making a referral.

People experiencing poor mental health (including people with dementia)

Requires improvement 

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

The practice had a lead nurse and GP who monitored all patients identified on the registers for dementia and mental health conditions. Systems were in place to invite these patients to an annual review. Patients could also be signposted to or directly referred to other services for support, for example substance misuse including alcohol and counselling.

Summary of findings

What people who use the service say

We spoke with 21 patients on the day of the inspection. We also reviewed eight patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. Patients were mostly satisfied with the service they received at the practice. Patients said they felt the practice offered a good service and staff were helpful and friendly.

We looked at the national patient survey published in January 2015. The survey found that 88.5% of respondents stated that they were able to get an appointment last time they tried and 89.5% said the last appointment they got was convenient.

When asked if they would recommend the practice to someone new to the area, 85% of respondents said they would, which was higher than the CCG average of 72%, and 91% of respondents rated their overall experience of the practice as good.

Areas for improvement

Action the service MUST take to improve

Ensure that all necessary pre-employment checks are obtained and appropriate evidence kept on file.

Ensure that Patient Group Directives (PGDs) are up to date and signed by both the GP and nursing staff.

Ensure there are systems in place to assess, monitor and improve the quality and safety of the service. For example the use audits, risk assessments and surveys.

Action the service SHOULD take to improve

Ensure the methods used to review and disseminate learning from significant events and near misses are robust.

Provide staff with up to date infection prevention and control training.

Ensure all staff understand the Mental Capacity Act 2005 and implications for their practice.

Review how confidentiality is maintained at the reception and prescription desks, by both staff and visitors to the practice.

Promote the availability of interpreter services.

Ensure all staff are aware of and can identify with the practice mission statement and values.

Penn Manor Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission lead inspector. The lead inspector was accompanied by a GP specialist advisor, a Practice Manager specialist and an Expert by Experience, who was supported by their personal assistant.

Background to Penn Manor Medical Practice

Penn Manor Medical Practice is located in Penn, a suburb of Wolverhampton in the West Midlands.

At the time of our inspection there were approximately 11,475 patients of all ages registered at the practice. The practice has a higher proportion of patients aged 65 years and above than the expected national average. The practice has 37% of the practice population who fall in this age range compared to the national average of 26.5%.

The practice has five GP partners and two salaried GPs, GP registrars, three practice nurses, one health care assistant, a practice manager and a team of reception and administrative staff, including medical secretaries. The practice is open between 8.30am and 6.30pm Monday to Friday, with extended hours between 6.30pm and 7.00pm every evening except Friday. Telephone calls for emergencies only are answered between 8am and 8.30am. The practice operates a telephone triage system for all GP partner appointments. Patients are initially provided with a telephone consultation and a decision made as to whether the patient needs a face to face consultation. Patients are able to pre book appointments with the registrars and the practice nurses. Telephone and face to face consultations are available from 8.30am until 6.30pm

The practice is a training practice for GP Registrars. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice also provides placements for Foundation Doctors (these are newly qualified doctors who are gaining a few months supervised general practice experience), as well medical students.

The practice provides a number of clinics for example long term condition management including asthma, diabetes and high blood pressure. It offers antenatal care, child immunisations, minor surgery and travel health.

Penn Manor Medical Practice holds a General Medical Services (GMS) contract with NHS England.

The practice has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out of hours service is provided by Prime Care, via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to 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

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

How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Wolverhampton Clinical Commissioning Group, Healthwatch and NHS England Area Team.

We carried out an announced visit on 5 May 2015. During our inspection we spoke to a range of staff including GPs, registrars, the practice nurses, the practice manager, and reception and administration staff, including medical secretaries. We spoke with 21 patients who used the service about their experiences of the care they received. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed eight patient comment cards sharing their views and experiences of the practice. We also spoke with representatives from two local care homes.

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 identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place. One of the practice nurses described an incident they had reported regarding the behaviour of a grandparent towards a child.

We saw there were safety records and incident reports for the last four years. This showed the practice had managed these consistently over time and so could show evidence of a 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, incidents and accidents. There were records of significant events that had occurred during the last four years and we were able to review these. Staff told us that significant events were usually discussed at the clinical team meeting, although no incidents had been discussed recently as only one had been reported during 2015. A system was not in place to discuss, review actions and ensure learning had taken place from past significant events. The practice manager and one of the GP partners had arranged to attend training on significant event reporting. The significant event form had also been amended to include an audit trail of discussions and actions taken as a consequence. 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. They showed us the system used to manage and monitor incidents. We tracked one incident and saw the record was completed in a comprehensive and timely manner. We saw evidence of action taken as a result and outcome. This incident related to an accidental injury to a patient. We saw that the patient was made aware of the incident and process of investigation fully explained.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff told us the practice manager was responsible for taking appropriate action in response to an alert. Nursing staff told us they were responsible for acting on any alerts relevant to their area of care.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing staff and administration staff about training. Although staff had not attended any recent training, they knew how to recognise signs of abuse in older people, vulnerable adults and children. All staff knew to speak with one of the GPs at the practice if they had any concerns. Staff knew where to find the contact details for the relevant agencies in working hours and out of normal hours.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children who could demonstrate that they had the necessary training to enable them to fulfil this role. They were able to show us examples of when patients at risk had been discussed to ensure the appropriate action had been taken. Staff were aware of which GP was the safeguarding lead, and told us they could also discuss any concerns with the practice manager.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about a patient including electronic and scanned copies of communications from hospitals.

There was a chaperone policy which was visible in the consulting rooms and advertised in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Members of the nursing team and a number of reception staff acted as chaperones. Staff had received appropriate training. None of the staff who acted as chaperones had criminal records checks through the Disclosure and Barring Service (DBS) checks in place. There were plans to obtain DBS checks for the nursing staff

but not the reception staff. Risk assessments had not been completed for reception staff who acted as chaperones. One of the GP partners spoken with told us that GPs routinely asked patients if they want a chaperone. The trainee GPs confirmed this and told us they also recorded the information in the patient notes. Patients spoken to told us they were offered a chaperone.

There was a system to highlight vulnerable adults and children on the practice's electronic records, so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or patients with learning disabilities. The practice reviewed all 80 year old patients not seen at the practice in the previous 12 month period. Through this review process they identified 10 adults. They acted on the information and set up system alerts to review these patients on a regular basis. There was a system in place that highlighted patients with caring responsibilities. This enabled the practice to involve carers in the care and treatment decisions for the person they cared for.

The practice worked with other services to prevent abuse and to implement plans of care. Staff told us they had a very good working relationship with the health visitors who visit the practice. Weekly child health clinics were held at the practice, and provided an opportunity to discuss any concerns regarding children. The GP safeguarding lead told us they reviewed childhood attendance at accident and accident and emergency monthly. They told us they used the alert system on the electronic patient notes to identify children who were frequent attendees at accident and emergency. This altered staff to discuss health promotion with the parent / guardian of the child when they next visited the practice.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. 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.

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.

Staff told us there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines kept in the nurses' room. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. However, a number of the PGDs seen had not all been signed by either the GP, the nursing staff or both. There were also a number of PGDs on file that were out of date. The practice manager told us they would review the PGDs and ensure the current PGDs were signed by the GP and nursing staff.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Any changes to medicines requested by either the hospital or the patient were reviewed by the GPs before the prescription was issued.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had established a service for patients to collect their prepared prescriptions at a number of locations and had systems in place to monitor how these medicines were collected.

The practice was supported by the Clinical Commissioning Group (CCG) prescribing advisor. The prescribing advisor visited the practice and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. The prescribing advisor could initiate changes to patient medicines in response to updates if agreed by the GPs. Staff told us patients were notified of the changes when they collected their prescriptions either from the practice or their local pharmacy.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Inadequate

Are services safe?

The practice nurses shared the lead role for infection control and prevention. Staff had not been provided with infection control training since 2011. We looked at the most recent infection control audit carried in February 2015 by the local hospital infection control team. The practice audit achieved 74% compliance and had put an action plan in place to address the issues highlighted.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Spillage kits were available to manage any spillage of bodily fluids.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received appropriate immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

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

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

The practice was unable to demonstrate that effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. Although a recruitment policy was in in place, there was no evidence to support it was being followed or that the required pre-employment information was obtained. This included criminal records checks through the Disclosure and Barring Service (DBS) checks (previously known as Criminal Records Bureau checks), relevant information about physical and mental conditions that relate to their ability to perform regulated activities, satisfactory evidence of conduct in previous employment and proof of identity.

The practice manager told us that there were plans to obtain DBS checks for all clinicians. There were no plans to obtain DBS checks for non clinical staff and risk assessments had not been carried out on the different staff groups to assess which staff needed to have this check in place.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Monitoring safety and responding to risk

The practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a contract in place with an external company, who had completed a risk assessment and health and safety audit of behalf of the practice in November 2014. The audit had identified a number of areas that needed addressing and the practice manager told us they had completed the majority of the work.

The practice did not have a risk log in place and had not completed any of their own risk assessments. The external company who had completed the health and safety audit identified that risk assessments needed to be completed and the practice manager said there was a programme in place to complete these.

Inadequate

Are services safe?

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 (which provides an electric shock to stabilise a life threatening heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan had not been reviewed for a number of years and contained out of date information.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Staff had attended fire training and several members of staff told us they had attended additional training to become fire marshalls. Other staff told us the fire alarm was tested weekly and they had attended fire drills.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs had lead roles for specific medical conditions and were responsible for reviewing guidance relating to their lead role, and implementing changes as required. One GP spoken with told us that any required changes were emailed to the other GPs and discussed at the clinical team meetings. The practice nurses we spoke with told us that new guidance was emailed to them.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and chronic lung disease and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff told us the GPs worked closely with secondary care services to support patients with long term conditions. For example a meeting with the lead consultation for diabetes was planned to discuss the transfer of patient care from the hospital setting to primary care.

We saw that the local Clinical Commissioning Group (CCG) bench marked the practice against other practices in the locality. This information was provided to the practice as part of their Practice Support Visit carried out by the CCG. Areas identified as requiring improvement had been discussed and an action plan developed. Two areas for improvement had been identified. The first was to ensure that all patients with the specific heart condition were on the correct medication and the second was to improve the uptake of the influenza vaccine in the over 65 years and at risk patient groups.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical review and managing information about vulnerable patients.

The practice did not have a robust system in place for completing two cycle clinical audits. One of the GPs spoken with told us that the trainee doctors regularly carried out audits but the results were not collected centrally by the practice. The practice was only able to show us one incomplete clinical audit. This audit related to whether the medication prescribed for patients with heart failure followed the NICE guidance. The audit found that 70% of patients in the audit group (seven out of ten patients) were not being treated in accordance with the guidelines. There was no evidence to support that those patients not being treated were followed up by the GPs, or evidence of re-audit cycle to demonstrate changes in practice. One GP spoken with described an audit that they had carried out and the changes in practice that had occurred as a consequence. However there was no written evidence to support this.

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The 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 there was a system in place to review QOF data and recall patients when needed. The practice used the electronic system to alert clinical staff to collect QOF data when patients attended for a consultation. The practice achieved 93.5% QOF which was above the local Clinical Commissioning Group average (92.8%) but below the national average (94.2%). The practice was outlier for QOF targets in relation to uptake of the influenza vaccination, expected prevalence of chronic obstructive pulmonary disease (chronic lung disease) and foot examinations for diabetic patients. The practice had taken action to improve the update of the influenza vaccines although the figures reflected patient choice. The practice explained that the relatively low prevalence of COPD was due to the demographics of the patient population and the input of one the GPs with special interest in respiratory medicine. This meant that patients were accurately diagnosed.

The practice offered all aspects of the avoiding unplanned admissions enhanced service. This is where the practice identified the most vulnerable patients and developed care plans to assist with avoiding admission to hospital. The practice manager told us the GPs had access to risk assessment tools to identify vulnerable patients in the electronic patient note system. The practice also offered enhanced services for minor surgery and insertion of intra uterine devices and contraceptive implants (to prevent pregnancy). The practice was not able to produce any audits to support the quality of these services.

Requires improvement

Are services effective?

(for example, treatment is effective)

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 was supported by the prescribing advisor from the local Clinical Commissioning Group, who flagged up relevant medicine alerts and identified patients on this particular medicine. The information was then either passed on to the GPs for them to action or changed by the prescribing advisor if there was an agreement in place.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual basic life support training. We noted a good skill mix among the doctors with one GP having an additional diploma in sexual and reproductive medicine, three GPs with additional qualifications in women's health and one GP with an additional qualification in dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). We saw there was a system in place to check that the practice nurses' registration with their professional bodies was in date. The practice manager told us they were looking into an online training and appraisal tool in preparation for revalidation for nurses with their professional body.

The practice manager told us that staff appraisals had not been carried out during the past two years. This meant the individual training needs had not been identified and action plans put in place. Training was recorded in individual staff files, and the practice did not have a structured system to identify what training staff had received or when it was due for updating. We also saw that although an induction programme was in place there was little evidence that the programme had been followed completely by a new member of staff. However our interviews with staff did confirm that the practice was proactive in providing training and funding for relevant courses. There was protected learning time each month, with staff attending training relevant to their role. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback about the practice and the training received from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, and smoking cessation. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma and diabetes were able to demonstrate that they had appropriate training to fulfil these roles. Each GP partner had a lead role for long term conditions and supported the nursing team with the management of these patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs. These meetings

Requires improvement

Are services effective?

(for example, treatment is effective)

were attended by district nurses and palliative care nurses and staff from the practice. All patients on the palliative care register were reviewed at these meetings, and any additional care requirements discussed.

We spoke with representatives from two local care homes. They told us they had a good working relationship with the practice, and the GPs respected the views and opinions of the staff.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them.

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

Consent to care and treatment

We saw that the practice had policies and guidance on consent, the Mental Capacity Act 2005, and the assessment of Gillick competency of children and young adults. Nursing staff spoken with demonstrated a clear understanding of Gillick competencies when providing care and treatment to children. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

Staff had not received training on the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Nursing staff spoken with told us if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment. They also told us that if they thought a person's mental capacity appeared to be deteriorating, they would carry out dementia screening tests and seek advice from the lead GP.

Staff told us that GPs had sought the patient's consent to certain decisions, for example, 'do not attempt cardiopulmonary resuscitation' (DNACPR) care plans. They told us the appropriate paperwork was completed and the out of hours service was informed. We spoke with representatives from two local care homes who told us that GPs discussed end of life care and the DNACPR care plans with the patient and their families, and kept the plans under review. One of the representatives told us how one of the GPs had provided reassurance to a relative regarding the decisions made around end of life care.

There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained and scanned on to the patient's notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. An assessment of the individual's mental capacity was recorded in the care plan and the template completed in the electronic patient record. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). There were 106 patients on the dementia register and care plans were in place for 82 (77%) of these patients.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. The practice manager told us that obesity had been identified as a health issue in Wolverhampton. The practice as part of a local campaign to encourage people to improve their fitness by completing a mile or more, either walking, swimming or cycling.

New patients were required to complete a health questionnaire as part of the registration process. This

Requires improvement

Are services effective?

(for example, treatment is effective)

included information about medical conditions, family history, smoking and alcohol intake. New patients were offered a 'new patient' health check following review of their questionnaire.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, in house smoking cessation programmes and healthy lifestyle clinics. The nursing staff told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. Information relating to health promotion and services was displayed on the television screen in the waiting room.

Patients could be referred to Healthy Lifestyles. This service was for well patients with medical conditions such as diabetes or depression for example. Patients were seen by health trainers and if they met the criteria, they could access the gym equipment located within the practice, and move on to discounted gym membership.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with or above the national average.

The practice was planning to offer NHS Health Checks to all its patients aged 40 to 75 years, who were not regularly seen by the GPs for any other medical condition.

The practice had a lead nurse and GP who monitored all patients identified on the registers for dementia and mental health conditions. Systems were in place to invite these patients to an annual review. The practice told us they referred patients to the mental health crisis team as required. Patients could also be signposted to or directly referred to other services for support, for example substance misuse including alcohol and counselling. The practice maintained a vulnerable patient register, and reviewed any information from out of hours services or accident and emergency, to identify if any of these patients would benefit from a review.

The practice's performance for cervical smear uptake was 77.6%, which was slightly below the national average of 82%. There was a policy to send reminders for patients who did not attend for cervical smears.

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 115 replies to the national patient survey carried out during January-March 2014 and July-September 2014 (published January 2015) and a survey of 200 patients undertaken by the practice, report dated March 2013. The evidence from these sources showed patients were satisfied with how they were treated and that this was generally with compassion, dignity and respect. For example, data from the national patient survey showed that 91% of patients rated their overall experience of the practice as good, which was above both the local Clinical Commissioning Group (CCG) (83.5%) and national (67.9%) average. The survey showed that 90% of patients felt that the doctor was good at listening to them, and 87% said the GP gave them enough time. Both of these results were above the local CCG average of 84% and 82% respectively.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received eight completed cards and they were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful and friendly.

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

We saw there was a confidentiality policy in place, and staff had received training in April 2015. All staff signed a confidentiality agreement and this was kept on file. Telephones were answered away from the reception desk so patient confidentiality was not compromised. There was a partition between the main reception desk and the prescription desk to prevent conversations being overheard. The practice did not have a system in place to allow only one patient at a time to approach the reception desk or prescription desk. This meant that patients could potentially overhear private conversations between patients and staff. We also overheard results being given to a patient at the reception desk and the couriers collecting prescriptions reciting patients' names and addresses.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. This information was also included in the practice brochure.

Care planning and involvement in decisions about care and treatment

The majority of patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey carried out during January-March 2014 and July-September 2014 showed 72% of practice respondents said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results. These results were comparable with the CCG average. The results were lower for the nurses, with 58% of practice respondents said the nurse involved them in care decisions and 73% felt the nurse was good at explaining treatment and results. Both of these results were below the CCG average.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us that interpreter services were available for patients who did not have English as a first language but these were rarely used. We spoke with two patients during the inspection who told us they would ask relatives to accompany them if they needed information translating. The availability of translation services was not promoted within the practice, on the website or in the practice brochure.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, those with mental health difficulties or dementia, complex health needs or end of life care. The practice had identified those patients most at risk of admission and individual care plans had been developed

Good

Are services caring?

and agreed for these patients. The practice worked closely with the multidisciplinary health care team (community staff and Macmillan nurses) and met three monthly to discuss patients with complex health needs and end of life care We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example with coronary heart disease, diabetes, chronic obstructive pulmonary disease (chronic lung disease) and asthma.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 87% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern, which was above the CCG (77%) and national (83%) averages. The score for nurses was 73%, which was slightly below the CCG (76.6%) and national (78%) averages. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Leaflets in the patient waiting rooms told patients how to access a number of support groups and organisations. Patients were asked on registration if they had any caring responsibilities and the computer system alerted staff if a patient also had caring responsibilities. The GPs recognised that they needed to be more proactive about asking patients about caring responsibilities to ensure they identified changing circumstances. The GPs had carer support packs available in their rooms to give to patients as required.

All patients identified as receiving end of life care were visited weekly co-ordinated by the practice. Systems were in place to notify staff if families had suffered a bereavement. Staff followed set procedures when notified of a patient's death to ensure that all referrals and appointments were cancelled. Booklets on how to cope with bereavement were provided for patients when they collected the death certificate. Each GP decided whether they wished to see families following a bereavement, usually when they collected the death certificate.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. For example, the practice offered extended hours each week for patients with work commitments or who were unable attend during routine opening hours. The practice offered a range of enhanced services, for example minor surgery, coil and contraceptive implant fitting. The practice also provided a range of clinics for the management of long term conditions, such as asthma, chronic obstructive airways disease (COPD), heart disease and diabetes.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a range of risk assessment tools to identify vulnerable patients. As part of an enhanced service the practice had identified patients most at risk of unplanned admissions. Care plans had been developed and agreed with these patients.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. A representative from the practice attends the monthly CCG meetings and reports back to the practice. One of the GP partners was the lead clinician for Macmillan care and another was the lead for respiratory care within the CCG locality. The practice manager was part of the medicines modernisation sub group.

The practice did not have a patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice was looking to set up a virtual PPG, and posters informing patients of this were displayed in the waiting room. There were also plans to add this information to the practice website.

We spoke with representatives from two local care homes. They told us they worked in partnership with the practice to meet the needs of the patients and spoke highly of the GPs and staff. They both told us that the GPs responded promptly to any requests for home visits.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, patients with a learning disability and refugees or migrants. Staff told us that these patients were supported to register as either permanent or temporary patients. The practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

The practice had access to translation services if required. The availability of translation services was not promoted within the practice, on the website or in the practice brochure. There was a mix of male and female GPs at the practice, so patients who preferred to see a female doctor were able to do so. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

Staff had not received training on equality and diversity. The practice did not have an equality and diversity policy, although information relating to equality and diversity will be included in the new staff handbook.

The premises and services had some adaptations to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building, with services for patients on the ground floor. There was a hearing loop system available for patients with a hearing impairment. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. There was a ramped access to the main entrance of the practice. There were no automatic doors at the main entrance to the practice or between the waiting room and the corridors to the consulting rooms which made access for wheelchair users difficult. The practice told us they had made enquiries about fitting automatic doors to the main entrance. Accessible toilet facilities were available for all patients attending the practice with suitable adaptations in place. Manual wheelchairs and cushions were available in the waiting room for patient use.

Access to the service

The practice brochure and the website outlined how patients could book appointments and organise repeat prescriptions online. The practice opened between 8.30am and 6.30pm Monday to Friday, with extended hours every evening except Friday between 6.30pm and 7.00pm.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Telephone calls for emergencies only were answered between 8am and 8.30am. The practice operated a telephone triage system for appointments with the GP partners and salaried GPs. Same day appointments were available with the GP registrars, and pre bookable appointments were available with the nursing staff. Patients telephoned the practice with brief details of their concerns and were contacted by either their GP of choice, or the duty GP. If the GP telephone assessment was that the patient needed to be seen or the patient wished to be seen an appointment was made for them. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The contact telephone number for the out of hours service was in the practice brochure.

The practice introduced the telephone triage system in May 2014 as a result of comments from patients about poor access to appointments. The practice told us the new system had improved patient access. Patients spoken with during the inspection were satisfied with the system in place, although they commented they didn't like having to wait for the GP to call them back. No one expressed any views about the appointment system on the completed comment cards. The practice participates in the NHS Friends and Family Test, and out of 10 completed surveys between January and April 2015, two patients commented that they wouldn't recommend the practice because of the telephone triage system. The data from the national patient survey carried out during January-March 2014 and July-September 2014 (published January 2015) indicated that 88.5% of respondents were able to get an appointment or speak to someone last time they tried, which as above the CCG and national average. We saw what 76% of respondents said their experience of making an appointment was good, which as above the CCG and national average.

The practice told us they had continually reviewed the telephone triage system during the 12 months since it had been implemented and minor changes had been made. They said a full audit of the system was due to be carried out during May 2015.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to patients in their own homes. The GPs were provided with printed information about the patient to take with them on visits. The practice visited a number of care homes on a regular day each week to review patients and visited all care homes on request.

The practice had good working relationships with the community midwives and health visiting teams. The community midwives provided antenatal care to patients in their own homes or at the practice. One of the GP partners took the lead role in Child Health Surveillance and undertook the NHS Newborn and Infant Physical Examinations (NIPE) and post natal checks for mothers. Family planning services were also available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Patients were made aware of how to complain through a complaints poster in the waiting room and information in the practice brochure. However, a complaints leaflet for patients to take away was not available. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We found that there was an open and transparent approach towards complaints. The practice had received 19 complaints during 2014 / 2015. The complaints had been handled satisfactorily and responded to in a timely manner. However, we found that the response letter to the complainant did not make reference to the Health Service Ombudsman. Learning from complaints was clearly recorded in the complaints log. The practice manager told us that learning was shared with staff by email or at meetings.

The practice did not have a system to review complaints annually to detect themes or trends, or hold a dedicated meeting to discuss and review actions from past complaints and ensure learning had taken place.

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 clear mission statement and values. The mission statement was included in the practice brochure. The mission statement was for patients to be confident that the practice will help them receive the care they require when they are worried about their health. In addition, the practice will work to provide innovative primary health care. The values included to show integrity and fairness to all, be courteous, good mannered and honest and to look after staff by supporting development, involvement and explaining decisions.

However, discussions with staff showed that the mission statement and values were not well known amongst staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically and in paper form. Review dates were included in most of the policies. Staff were aware of how to access both the electronic and paper copies.

There was a clear leadership structure with named members of staff in lead roles for clinical practice. For example, there was a lead for infection control and each of the GP partners had lead roles, including safeguarding, older people, dementia and long term conditions. We spoke with a number of staff from different departments and they 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.

The practice had some systems in place to assess and monitor the quality of services. However, we found areas where systems to promote robust governance were not always in place or were inconsistently followed. For example the practice had not followed their recruitment policy when recruiting new staff. This included ensuring good conduct in previous employment and health checks. The recruitment policy made no reference to obtaining Disclosure and Barring Service Checks. The result of not following governance in a robust way could put a patient at increased risk of harm from improper treatment or avoidable illness.

There was no evidence to support that two cycle clinical audits had taken place and were used to monitor quality or systems to identify where action should be taken. The audit seen was not a completed audit cycle where the practice was able to demonstrate the changes resulting since the initial audit.

External peer review was provided by the local Clinical Commissioning Group (CCG) through the Practice Support Visit, which was carried out in February 2015. The report from the visit identified areas which required improvement and the practice had developed an action plan.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is an incentive scheme which rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing above the local CCG average. However, we saw that QOF data was not regularly discussed at the clinical team meetings.

The practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a contract in place with an external company, who had completed a risk assessment and health and safety audit of behalf of the practice in November 2014. The practice did not have a risk log in place. The practice manager told us that individual risks were identified through audits.

Leadership, openness and transparency

We found a lack of leadership and governance relating to the overall management of the service. There was no clear lead for the various aspects of practice management, and the practice was unable to demonstrate strong leadership to improve safety, outcome for patients or learning from significant events or complaints. The introduction of the telephone triage system had resulted in fewer opportunities for clinical staff to meet informally to discuss issues on a day to day basis. This meant less opportunity to communicate with colleagues other than within the formal staff meetings.

We saw that a range of staff meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to

Are services well-led?

Requires improvement

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

raise issues at team meetings. We looked at the agenda for the practice meetings. The meeting was used to discuss a range of topic, including delivery of enhanced services and feedback from the local Clinical Commissioning Group.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as the induction policy and grievance policy which were in place to support staff. The policies were all stored electronically and staff we spoke with knew where to find these policies if required.

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

The practice had previously gathered feedback from patients through patient surveys, comments and complaints. The last patient survey was undertaken in February / March 2013. The practice did not currently have a Patient Participation Group (PPG) to address the issues highlighted in the survey. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice was actively trying to introduce a PPG and notices involving patients to become involved with on display in the waiting room. The practice did participate in the NHS Friends and Family Test, although feedback rates were poor.

The practice gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had a good working relationship with the management.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. They confirmed the practice was very supportive of training and that they had monthly protected learning time. However we saw that staff appraisals had not been carried out during the past two years.

The GPs and nursing staff told us that significant events were shared with staff at clinical team meetings. However the minutes of meetings we saw did not demonstrate the detail of the discussions or of any learning that had taken place. This meant that staff who were not in attendance were not able to update themselves. We did not see any evidence to support that a log of all significant incidents was maintained or that annual review took place. The practice could not demonstrate that there was a robust system in place for completing two cycle clinical audits or improvement in outcomes for patients as a consequence. There was not a culture of learning from experience at the practice.

Several of the GP partners were responsible for the induction and overseeing of the GP registrar's training. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with three GP registrars who told us there was strong leadership within the practice. They told us they felt well supported and secure in their role.

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 People using the service were not protected against the risks of inappropriate or unsafe care and treatment because the required information as outlined Regulation 19 and Schedule 3 (Information Required in Respect of Persons Seeking to Carry On, Manage Or Work For The Purposes of Carrying On, A Regulated Activity) was not recorded. Regulation 19(3)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People using the service were not protected against the risks of inappropriate or unsafe care and treatment because of the lack of systems and processes in place to assess, monitor and improve the quality and safety of the service. Regulation 17(1) (2)(a)(b)(d)(i)(ii)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service were not protected against the risks of inappropriate or unsafe care and treatment because of the lack of safe and proper management of medicines. Regulation 12(2)(g)