Melbourne Street Surgery

Quality Report

Melbourne Street Surgery,
56 Melbourne Street,
Leicester,
Leicestershire,
LE2 0AS
Tel: 01162536299
Website: www. johnsonmedicalpractice

Date of inspection visit: 08/07/2014
Date of publication: 30/09/2014

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.

Contents

Summary of findings

Overall summary

Most patients told us they were happy with the care and treatment they received. Patients felt listened to and able to raise any concerns about the service with staff.

Procedures were in place to report and record safety incidents and concerns. The practice learned from incidents, complaints and patient feedback, and took action to ensure that patients were protected from harm and received safe care.

Most patients considered that the service was caring, and treated them with respect and maintained their confidentially. Procedures were in place to ensure that patients consent was obtained before they received care or treatment, and that staff acted in accordance with legal requirements where people were unable to consent.

The service worked in partnership with other providers and services to meet the needs of patients in an effective way. Further services were being provided to enable more patients to be treated locally at the practice.

Staff changes and the use of temporary GPs had significantly reduced in the last 12 months following the appointment of further staff. An established staff team was in place to ensure that patients received consistent standards of care and service.

Staff received appropriate support, training and an appraisal to enable them to carry out their duties. Staff worked well together as a team and felt supported in their roles.

The practice had undergone significant changes in the last 12 months to ensure the service was well-led, and responded to patients' needs.

The services met the needs of the six population groups we looked at, and were safe, effective, caring, well-led and responsive to patients' needs.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe.

Patients told us they felt safe when using the service.

Procedures were in place to protect patients from abuse and harm. The practice learned from incidents, complaints and patient feedback, and took action to ensure that patients were protected from avoidable harm and received safe care.

Sufficient staffing levels were provided to meet patients' needs.

Systems were in place to ensure that the practice was clean, safe and well maintained.

Arrangements were in place to protect patients against the risk of infection and associated with the unsafe use of medicines.

Are services effective?
The service was effective.

Patients told us they were involved in decisions about their care and treatment, and were supported to make informed choices.

New patients were offered a health check to help staff to understand their current medical situation, and to make any necessary plans for future treatment and reviews if necessary.

The practice worked in partnership with other providers and services to meet the needs of patients in an effective way.

Discussions with staff and records showed that staff received appropriate support, training and an appraisal to enable them to carry out their duties. Newly appointed staff received induction training to support them to carry out their work.

Are services caring?
The service was caring.

Patients described the staff as friendly, caring and helpful, and felt that they treated them with dignity and respect, and spoke to them politely.

We saw that patients' privacy, dignity and confidentially were maintained. We observed staff being respectful, polite and friendly when dealing with patients.

Summary of findings

Arrangements were in place to ensure that patients consent was obtained before they received any care or treatment, and that staff acted in accordance with legal requirements where patients did not have the capacity to consent.

Are services responsive to people's needs?
The service was responsive to people's needs.

Most patients told us they were satisfied with the appointment system, and were able to get an appointment or were offered a telephone consultation, where needed.

The opening times and appointment system had been extended to enable patients more choice and to book an appointment at their preferred times.

The practice worked in partnership with other professionals and services to meet patients' needs in a responsive way. Further services were being provided to enable more patients to be treated locally at the practice.

Systems were in place for handling and responding appropriately to complaints made by patients, or people acting on their behalf.

Are services well-led?
The service was well-led.

Most patients and representatives said that they felt that the practice was generally well managed**.**

Staff worked well together as a team and had opportunities to share information and express their views through regular meetings.

There were clear lines of responsibility within the staff team to ensure that the service was well managed. The systems for driving improvements and monitoring the effectiveness of the care and services had been strengthened.

There was a clear desire within the team to improve the service for patients. Measures were in place to obtain patients views about the service and to act on their feedback to improve the service.

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
Patients 65 years and over were offered an annual health check.

All patients 75 years and over were allocated a named GP to offer continuity of care to ensure that their needs were being met. Health care plans were provided for patients over 75 years to help avoid unplanned admissions to hospital.

Carers were identified and supported to care for older people. Home visits were carried out for elderly housebound patients.

People with long-term conditions
Patients were offered an annual health review including a review of their medication, and when clinically appropriate. Home visits were carried out for housebound patients.

Where possible, clinicians reviewed patient's long term health conditions and needs at a single appointment, to prevent them from attending various reviews.

Referrals to specialists and other secondary services were made in an appropriate and timely way.

Mothers, babies, children and young people
Priority was given to appointment requests for babies and young children.

The practice provided antenatal and postnatal care. The midwife and health visitor held regular clinics at the practice.

The GP safeguarding lead regularly met with the health visitor to discuss looked after children and children on the safeguarding register, to share information, concerns and best way to support the families.

The practice offered contraceptive services, including advice on contraception and sexual health for teenagers.

The working-age population and those recently retired
The practice provided extended opening hours to enable patients to attend in an evening. Patients were also able to book non urgent appointments around their working day by telephone, on line or using the 24 hour automated booking service.

The practice offered a 'choose and book' service for patients referred to outpatient services, which enabled them greater flexibility over when and where their test took place.

Summary of findings

NHS health checks were offered to patients over 40 years.

People in vulnerable circumstances who may have poor access to primary care

The practice provided extended opening hours for patients who may not attend during the day.

The practice discussed patients in vulnerable circumstances at joint meetings with relevant health and social care professionals, to ensure they received appropriate care and support.

Carers of vulnerable patients were identified and offered support.

Patients with a learning disability were offered an annual health review including a review of their medication. They also had a named GP to offer continuity of care to ensure that their needs were being met.

People experiencing poor mental health

Staff worked closely with local mental health teams to ensure patients' needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients' medicines were also reviewed annually and when clinically appropriate.

A mental health worker and counsellor held regular clinics at the practice to support patients.

Patients were enabled to access emergency care and treatment when experiencing a mental health crisis.

Summary of findings

What people who use the service say

We spoke with eight patients and received comments cards from a further 16 patients. We also spoke with two members of the Patient Participation Group (this consists of a group of staff and patients who work together to discuss the work of the practice and to identify areas for improvement) and the managers of four care homes (for older people and younger adults with disabilities) where patients were registered with the practice.

Patients told us they felt safe and listened to, and able to raise any concerns with staff if they were unhappy with the care or the service. They knew how to make a complaint.

Most patients told us they were happy with the care and treatment they received, and were seen promptly where needed. They also said that they were involved in decisions about their care and treatment, and were supported to make choices.

Patients described the staff as friendly, caring and helpful, and said that they felt that they treated them with dignity and respect, and spoke to them politely. However, two care home managers said that certain GPs had limited contact and did not spend much time talking with elderly patients when they visited.

Several patients told us that the service had improved in the last 12months. However, they felt that further improvements were needed in regard to answering phone calls, the availability of urgent appointments, and ensuring that patients were not left waiting long to see a GP.

Most patients said that they felt that the practice was generally well managed and responded promptly to their needs. One care home manager did not share this view.

Patients told us that they found the practice was always clean and tidy.

Patients were asked for their views and they were acted on to improve the service. The practice worked in partnership with the PPG. The PPG carried out a patient satisfaction survey in 2013, which 37 patients completed. The responses showed that patients were generally satisfied with the service. 82% of patients said that they were able to get a routine appointment in seven days, 97% said that the reception staff were helpful, 100% said that they were able to get an urgent appointment or were offered a telephone consultation. An action plan was in place in response to comments received.

An independent GP patient survey was carried out in 2014, which 113 patients completed. Some responses indicated that patients were not satisfied with aspects of the service including getting through to the practice by phone, the availability of appointments and the level of privacy when speaking to receptionists. 57% of patients said that they would recommend the practice to someone new in the area.

Areas for improvement

Action the service SHOULD take to improve

The provider should update the recruitment policy to detail all stages of the recruitment process and information obtained, to ensure that staff employed are suitable to carry out the work.

The provider should carry out regular fire evacuation drills to ensure that staff know what to do in the event of a fire.

The provider should monitor the medicines fridge temperature to ensure it is checked daily and that the medicines are stored at the correct temperature.

The provider should provide further training for GPs to read electrocardiogram (ECG) test results to enable ECG's to be carried out at the practice.

The provider should provide further training on the Mental Capacity Act 2005 to ensure that all staff understand the principles of the act and the safeguards.

Summary of findings

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice employed a pharmacist to oversee the management of patients' medicines to ensure that medicines were prescribed appropriately and safely.

The practice was part of a cardiology project to enable GPs to manage patients with mild to moderate heart failure. This enabled more patients to be treated locally by GPs.

The clinical staff had received comprehensive training from specialist staff to enable them to care for more patients who have diabetes, and reduce the need for hospital referrals.

Two of the GP partners were End of Life mentors, having received comprehensive training on palliative care, to enable them to provide advice and support to clinicians including other GP practices in Leicester City centre, to ensure that patients received appropriate care.

Melbourne Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team included two CQC inspectors, a GP, a GP practice manager and an expert-by-experience. An expert by experience is somebody who has personal knowledge of using services either as a patient or as a carer of a patient who has used similar services.

Background to Melbourne Street Surgery

Melbourne Street Surgery provides primary medical services to approximately 2, 500 patients in the Highfields area of Leicester. The practice provides 12 GP sessions a week. It also provides a range of services including minor surgery, minor injuries, family planning, maternity care, blood testing, vaccinations, ear syringing, smoking cessation, mental health, drug and alcohol services and various clinics for patients with long term conditions.

The practice is located in non-purpose built premises. It is managed by Johnson Medical Practice who also manages Hilltop Surgery in Leicester, which is located nearby. Patients can attend either practice. We did not inspect Hilltop Surgery. The staff team includes three partners and three salaried GP's, one practice nurse, two health care assistants, a practice manager and an assistant practice manager who work across the two practices. Melbourne Street Surgery is a training practice for doctors in training.

The practice had opted out of providing the out-of-hours service.

Why we carried out this inspection

We inspected Melbourne Street Surgery on 08 July 2014 as part of our new inspection programme to test our approach going forward. The practice had not previously been inspected.

How we carried out this inspection

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We carried out an announced visit on 08 July 2014.

During our visit we checked the premises and the practice's records. We spoke with a range of staff including, the practice nurse, a health care assistant, three GP's, reception and clerical staff, the practice manager and assistant practice manager. We also received comments cards and spoke with patients and representatives who used the service, including two members of the Patient Participation Group (PPG). The PPG consists of a group of staff and patients who work together to discuss the work of the practice and to identify areas for improvement.

Following our visit we spoke with two health care professionals who worked closely with the practice.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We carried out an announced visit on 08 July 2014.

During our visit we checked the premises and the practice's records. We spoke with a range of staff including, the practice nurse, a health care assistant, three GP's, reception and clerical staff, the practice manager and assistant practice manager. We also received comments cards and spoke with patients and representatives who used the service, including two members of the Patient Participation Group (PPG). The PPG consists of a group of staff and patients who work together to discuss the work of the practice and to identify areas for improvement.

Following our visit we spoke with two health care professionals who worked closely with the practice.

to get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care

People experiencing mental health problems

Are services safe?

Our findings

Safe patient care

Patients told us they felt safe when using the service.

Effective systems were in place to report and record significant events, safety incidents, concerns and near misses. Discussions with staff and records showed that safety incidents and concerns were dealt with quickly and effectively. Incidents and concerns were discussed at the clinical and team meetings. Staff were aware of their responsibility to promote safety and to report incidents, and received feedback as to what action had been taken.

We saw that effective systems were in place to ensure that relevant staff were informed of patient safety alerts, to protect patients and the staff team against risks to their safety and to ensure patients received safe care.

Learning from incidents

Staff told us that the practice was open and transparent when things went wrong. There was evidence that learning from incidents took place, which was shared with the staff. Records showed that accidents and incidents were reviewed to identify any patterns or issues, and that appropriate actions had been taken to minimise further occurrences. For example, it had been identified that a patient's blood results had initially been interpreted and coded wrongly, and had therefore not been followed up. To avoid further incidents all results were reviewed and coded by a GP

Safeguarding

We found that robust recruitment procedures were followed in practice to ensure that staff had the relevant skills and experience and were suitable to carry out their work. However, the recruitment policy did not detail all stages of the process and information obtained to ensure that robust procedures were followed.

We checked a random sample of staff recruitment files. The records contained essential information and checks before staff began work, to ensure they were suitable to carry out the work.

We saw evidence of checks to ensure that the practice nurse and GPs were registered to practice with the relevant professional body. A computer system had recently been set up to highlight four weeks in advance when GPs and nurses registration to practice, indemnity insurance and safeguarding training were due for renewal. The system will help the provider to oversee that the above checks have been renewed, to ensure that clinical staff remain fit to practice.

Policies and processes were in place to protect patients from abuse and harm. An alert system was in place on patients' computerised records, where an individual was at risk of abuse, on the child protection register or vulnerable. This alerted staff to ensure they received appropriate support, and that relevant professionals were involved, where required.

Staff had access to the safeguarding policies for adults and children. Staff we spoke with had an understanding of safeguarding issues and who they should report concerns to, if abuse was alleged or suspected. They said that they felt able to report any concerns to senior staff. Clinical staff assured us that they had made safeguarding referrals where abuse was reported or suspected. They recorded the information in patients' records.

Records showed that all staff had received the appropriate level of training to ensure they understood their responsibilities under safe guarding procedures.

One of the GPs was the designated lead for safeguarding. As part of their role they attended regular meetings with relevant professionals to discuss patients who were at risk of abuse, on the child protection register or vulnerable. Significant information was recorded in patient's records.

Monitoring safety and responding to risk

We saw that the practice had systems in place for identifying and managing risks to staff and patients. Clinical staff assured us that they assessed risks to individual patients and took action to protect them from harm. For example, patients experiencing a mental health crisis were urgently referred to relevant services to enable them to receive appropriate care and treatment.

We were assured that the staffing levels were reviewed to meet patients' needs and ensure their safety.

Medicines management

Several patients told us that the systems in place for obtaining repeat prescriptions worked well to enable them to obtain further supplies of medicines.

We found that policies and processes were in place to protect patients against the risks associated with the unsafe use of medicines. The practice employed a

Are services safe?

pharmacist to oversee the management of patients' medicines to ensure they were prescribed appropriately and safely. Safe systems were in place for obtaining repeat prescriptions, and to ensure that patients' medicines were regularly reviewed.

We saw that medicines including vaccines were stored properly and that staff carried out regular stock checks to ensure they were in date.

Various medicines including vaccines were kept in a locked fridge. We looked at the daily fridge temperatures for the period 1 February 2014 to 7 July 2014. Prior to March 2014, the temperature had not been recorded daily in line with the provider's policy. The practice manager had identified this issue and had taken action to ensure that the temperature was checked and recorded daily. This provided assurances that the medicines were stored at the correct temperature.

Cleanliness and infection control

Patients told us that they found the practice was always clean and tidy.

We found that the premises were visibly clean and hygienic. Procedures were in place to minimise the risk and spread of infection, and to ensure that the premises were clean.

Effective systems were in place to monitor the cleanliness and the control of infection, although some information in the provider's infection control policy did not reflect what was happening in practice. For example, we saw that routine infection control checks were carried out to monitor the cleanliness and the control of infection. The policy did not state how often the checks should be undertaken.

Two clinical staff were the designated leads for infection control, with responsibility for completing regular checks to ensure that the premises were clean and hygienic. Records showed that the last infection control check was completed on 17 May 2014. The report included action taken to rectify shortfalls that had been highlighted. The findings and any remedial actions were shared with the staff team.

Staffing and recruitment

Staff we spoke with assured us that the staffing levels were reviewed to meet patients' needs and ensure their safety.

For example, in response to feedback from patients that they were waiting too long to get through to the practice by phone, the number of staff answering calls in the morning had increased.

Most of the reception and administration staff had worked at the practice for a number of years. GP changes and the use of temporary doctors had significantly reduced in the last 12 months following the appointment of further staff. A stable staff team was in place to ensure that patients received consistent standards of care and service. The practice used one locum doctor on a long term contract, who had worked at the service since September 2013.

To support the continued development of its services to enable more patients to be treated locally, the practice had taken steps to appoint a second practice nurse. However, recent attempts to appoint to this position had been unsuccessful. The practice was looking at alternative ways of increasing the skill mix to provide support, until a second practice nurse was appointed.

GPs we spoke with described the arrangements in place to ensure that they were up-to-date and fit to practice. This included collecting supporting information towards their annual appraisal and revalidation of their practice, to support that they are providing safe and effective care. One of the GP partners was responsible for overseeing that all doctors received an annual appraisal of their work, and were competent to practice.

Dealing with Emergencies

Systems were in place for dealing with emergencies. Staff we spoke with were aware of the arrangements in place for dealing with emergencies that might interrupt the running of the service. Staff had access to the business continuity plan, setting out how the practice would manage serious incidents or events, to ensure peoples' safety and the continued running of the service.

Staff we spoke with were aware of the procedure to follow when the fire alarm went off, and said that they had received training on fire awareness. The training records showed that non clinical staff had received recent training on health and safety. The practice manager assured us that the health and safety training included fire safety awareness, which all staff had completed. She agreed to update the records to show this.

The provider's fire safety policy stated that a fire evacuation drill should be carried out at least once a year. The practice

Are services safe?

manager acknowledged that a fire drill had not been completed in the last 12 months. However, regular fire drills were due to be carried out from August 2014 to ensure that staff knew what to do if the fire alarm went off and in the event of a fire.

Equipment

We found that systems were in place to ensure that all equipment was regularly maintained and safe to use, including servicing the fire alarm system and emergency lighting, and testing the electrical appliances. Records showed that the staff regularly checked the medical equipment to ensure it worked properly and was safe to use. Equipment that needed calibrating was checked at regular intervals to ensure it worked properly.

Staff we spoke with confirmed that all equipment was safe to use. They also said that there was sufficient equipment available to carry out required tests, or to provide the treatment patients needed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

Procedures were in place to ensure that patients care and treatment was delivered in line with best practice standards and guidelines. Clinical staff told us that they automatically received updates relating to best practice and safety alerts through the email system. They also attended weekly clinical meetings where they discussed clinical issues and changes to guidance and best practice.

We saw that various clinical policies and procedures had been updated to ensure these were in line with relevant standards and best practice.

We found that systems were also in place to ensure that older people, those in vulnerable circumstances, with long term conditions and experiencing poor mental health received regular health reviews, including a review of their medicines.

The practice employed a pharmacist to oversee medicines patients' were taking, to ensure they were prescribed effectively and safely in line with prescribing standards.

Management, monitoring and improving outcomes for people

We saw that the practice had a system in place for completing clinical audit cycles to provide assurances as to the quality of care, and to improve the outcomes for patients. For example, recent audits were completed to identify practice in regards to three prescribed medicines that required careful monitoring. Improvement plans had been put in place to ensure the effectiveness and safety of the medicines, and further audits had been carried out to check that the necessary changes had been made and sustained.

Staff told us that the outcome of audits was communicated through the team and clinical meetings.

Clinical staff told us that they undertook lead roles to promote best practice within the team and to oversee the quality of care and to drive improvements. Lead roles including palliative care, infection control, management of medicines, learning disabilities and dementia.

Records showed that weekly clinical meetings were held involving the GPs, practice nurse and the practice manager. The meetings enabled the staff to discuss clinical issues and peer review each other's practice, resulting in improvements in care. The timetable of clinical meetings for 2014 included safeguarding, clinical practice, diabetes, palliative care, smoking cessation, drugs and significant events. Relevant professionals were invited to attend the meetings to share best practice and promote high quality care.

The practice was involved in various projects to improve the outcomes for patients and to enable more people to be treated locally by GPs. For example, patients at risk of developing a chronic respiratory condition and coronary artery disease were offered screening to enable the conditions to be detected and treated early. The practice was also part of a cardiology project to enable GPs to manage patients with mild to moderate heart failure. The clinical staff had also received training by specialist staff to enable them to care for more patients who have diabetes, and reduce the need for hospital referrals.

We noted that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved a total of 97.8%. This was above the average for practices in England. QOF is a voluntary incentive programme, which enables GP practices to compare their achievements and to improve the quality of general practice.

Staffing, equipment and facilities

There were clear policies and procedures in place in regard to staff induction, training and appraisals, to ensure that people working at the practice received appropriate training and support to carry out their work effectively. We saw completed induction checklists in staff files, which had been signed by the manager and the staff member.

We found that the staff team had appropriate knowledge, skills and experience to enable them to deliver the service effectively.

Staff we spoke with told us they worked well together as a team and felt well supported. They also said that opportunities for development were encouraged and supported. The practice closed for half a day every third Wednesday each month to enable all staff to receive time for learning. Discussions with staff and records showed that staff received appropriate support, training and an

Are services effective?

(for example, treatment is effective)

appraisal to enable them to carry out their work effectively. Staff did not receive regular one to one meetings. However, it was apparent that they received supervision through peer support and regular team meetings they attended.

GPs we spoke with described the arrangements in place to ensure that they were up-to-date and fit to practice. This included collecting supporting information towards their annual appraisal and revalidation of their practice, to support that they are providing safe and effective care. One of the GP partners was responsible for overseeing that all doctors received an annual appraisal of their work, and were competent to practice.

Staff told us that they had attended recent training on infection control, and they had access to the provider's policy and guidance. However, the records did not show that the GPs had attended training on infection control. The practice manager assured us that they had completed this. She acknowledged that the new matrix did not include all training that staff had attended, and she agreed to update the records.

Staff and most patients we spoke with told us there was enough staff at the practice. However, a couple of patients said that they felt that more GPs were needed to improve access to appointments, and to reduce the time they spent waiting to see a doctor at the practice.

The GPs and practice staff we spoke with were confident that patients were seen urgently, where required. A GP was on call each day and patients were offered a telephone consultation, where appropriate. A reserve of appointments was also available. We observed these systems in practice and found that staff made every effort to ensure that patients who needed to be seen, had access to a GP or the practice nurse.

Staff told us that they had access to appropriate equipment to meet patients' needs. We saw that systems were in place to ensure that all equipment was regularly checked to ensure it was suitable to use. The practice had an electrocardiogram (ECG) machine, which records the rhythm and the electrical activity of a patient's heart. The health care assistants had received training to carry out ECG tests. However, the tests were not carried out at the practice as the GPs required further training to read the results. Patients requiring an ECG test were required to attend other services, and the results were forwarded to the practice.

Working with other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, local mental health teams and district nursing services to meet patients' needs in a responsive way.

Clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who had complex needs, in vulnerable circumstances or were receiving end of life care, to ensure that they received appropriate support and treatment.

Staff described the systems in place to ensure that essential information about patients was shared with relevant agencies at the earliest opportunity. For example, welfare and safety concerns relating to children were shared with relevant professionals including health visitors and school nurses. Staff told us that they worked closely with the out-of-hours service to ensure that staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid inappropriate hospital admissions.

We saw that systems were also in place to ensure that hospital discharge letters were seen, and that referral letters were promptly sent. Changes had been made to ensure that patients test results were promptly seen, correctly coded and followed up by a GP.

Health, promotion and prevention

A range of health promotion information was available to patients, including information on smoking cessation, cancer awareness, victim support, memory loss and diabetes.

Systems were in place to identify patients who had carer responsibilities to enable the staff to offer them support. We saw that various information was available for carers to support them in their caring role and to signpost them to relevant services.

We saw that new patients completed a health form, which provided essential information for staff about their health needs and risk factors in their medical and social history. New patients were also offered a health check with a clinician to help staff to understand their current medical situation, and to make any necessary plans for future treatment and reviews if necessary.

Are services effective?

(for example, treatment is effective)

Systems were in place to encourage patients to attend smear tests, where appropriate.

The practice had identified patients who were at high risk, or who frequently accessed the out-of- hours service, or attended hospital and Accident and Emergency departments, to enable them to receive further support, with a view to reducing the need for them to access the above services.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients described the staff as friendly and helpful, and said that they treated them with dignity and respect, and spoke to them in a caring way. Patients said that they felt listened to and that their views and wishes were respected. However, two care home managers told us that certain GPs did not spend much time with elderly patients, discussing their care and treatment. The practice manager agreed to raise this issue with the GPs through the clinical practice meetings.

Staff and patients we spoke with were aware of the chaperone policy. There was a sign explaining that patients could ask for a chaperone during examinations if they wanted one. Records showed that relevant staff had received training on how to chaperone a clinician, and were aware of the procedure.

Some patients preferred to see a GP or nurse of the same gender if they required an examination. In response to feedback from patients the practice appointed a further female GP in September 2013, to enable patients the choice to see a male or female GP.

The results of the 2013 PPG (this consists of a group of staff and patients who work together to discuss the work of the practice and to identify areas for improvement) patient satisfaction survey and the 2014 independent patient survey showed that some patients were not satisfied with the level of privacy when speaking with reception staff at the practice. In response to comments received the practice had installed a radio and re-positioned the television to serve as a distraction. Reception staff had also received further training to ensure conversations with patients were kept discreet.

We observed staff being respectful, polite and friendly when dealing with patients. Patients' confidentially was maintained. A sign was displayed informing patients that a room was available if they wished to have a private conversation with staff away from the reception area.

We saw that a range of information leaflets were available in the reception area; the literature was all in English. The practice manager assured us that the information was available in different language formats, where required. A poster was displayed in the waiting area informing patients of this. In addition, most of the reception staff spoke relevant languages, which enabled them to communicate with most patients who did not speak English. Patients could also access written information online in different formats if their first language was not English.

Staff assured us that bereaved carers known to the practice were supported by way of a personal visit or phone call from a GP, to determine whether they needed any practical or emotional support. We noted that the carers file and information on the practice website sign posted carers to support groups available.

Involvement in decisions and consent

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to.

Patients who phoned the practice to make an appointment. were asked if they wished to see a specific doctor. The reception staff tried to accommodate their wishes to see their preferred GP.

Arrangements were in place to ensure that patients consent was obtained before they received any care or treatment, and that staff acted in accordance with legal requirements where patients did not have the capacity to consent. We saw that the practice had a policy in place in regards to making decisions about patients care and treatment and acting in their best interests, when a person was unable to make decisions and give consent.

Records showed that 11 out of 19 staff had received training on the Mental Capacity Act 2005 to ensure staff understand the principles of the act and the safeguards.

We found that appropriate arrangements were in place for patients receiving end of life care, to ensure that their wishes were respected, including decisions about resuscitation and where they wished to die. The practice supported carers to care for relatives receiving end of life care.

An information file was available to carers, which included useful information about caring for a relative, and support available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Most patients told us they were happy with the care and treatment they received.

The managers of three care homes we spoke with told us that the practice usually responded promptly to patients' needs, and visited where required**.** However, one manager felt that the practice could be more responsive to patients 'needs. They recalled occasions where patients' had not been seen promptly or received a telephone consultation, which delayed their treatment. The practice manager confirmed that she was aware of the issues, and that action had been taken to ensure that the practice responds promptly to patients' needs.

The practice provided a wide range of services to meet patients' needs. Further services and clinics were being provided to enable more people to be treated locally by GPs. For example, the practice now provided anti-coagulant (this involves monitoring patients on medication to thin their blood) and deep vein thrombosis clinics to patients whose condition was well controlled. These services were previously provided by the hospital.

The practice worked closely with local community nursing teams and the Macmillan service to ensure that patients' end of life care took account of their needs and wishes, and responded to changes in their needs.

The practice also worked in partnership with the Patient Participation Group (PPG) and responded to information to improve its services to meet patients' needs. The PPG consists of a group of staff and patients who work together to discuss the work of the practice, and to identify areas for improvement. For example, in response to feedback from patients regarding the cost of phone calls, the practice had changed the phone system to a local number to reduce the cost of calls.

Access to the service

Most patients told us they were able to get an appointment or were offered a telephone consultation, where needed. However, a few patients said that they had difficulty at times in getting through to the practice by phone, obtaining an urgent appointment, and were left waiting a long time at the practice to see a GP.

We observed that, on the day of our inspection that a few people waited more than 15 minutes to see a GP.

Patients had the option to book an appointment in person, by telephone, on line or by using the automated booking service. Extended opening hours were available until 8 pm on Monday and until 6.30pm Tuesday to Friday to enable patients to attend in an evening.

Records showed that the appointment system and call times were regularly checked to ensure that the practice responded to patients' needs. For example, in response to feedback from patients that they were waiting too long to get through to the practice by phone, the number of staff answering calls in the morning had increased.

Systems were also in place to prioritise emergency and home visit appointments or phone consultations for patients who were not well enough to attend the surgery.

The practice monitored the number of patients who did not attend appointments each month. Further measures had been put in place to improve the attendance levels. Appointment reminders were sent. The booking of non-urgent appointments in advance had changed from four to two weeks, to increase the likelihood of patients attending.

The premises were accessible to patients, including people with mobility difficulties or in a wheelchair.

The patients at the practice were from various ethnic groups with the largest group being of Asian origin (37%). A number of patients' first language was not English. The practice website provided comprehensive information about the services provided, and included a translation facility, which enabled patients to access the information in their first language.

The practice manager told us that most of the staff were of Asian origin and spoke relevant languages, which enabled them to communicate with various patients who did not speak English. We observed the reception staff communicating with several patients in their first language. Staff told us that they also had access to interpreting and translation services and they knew how to access these.

Concerns and complaints

Patients we spoke with told us that they felt listened to and able to raise any concerns about the service with staff. They had access to the complaints policy and knew how to complain if necessary, but they had not had cause to do so.

Are services responsive to people's needs?

(for example, to feedback?)

We saw that there was a system in place for handling complaints and concerns about the service, to ensure they were investigated and responded to appropriately. The complaints policy was in line with recognised guidance, and there was a designated person who handled all complaints.

Records of complaints received in the last 12 months showed that patients' concerns had been acknowledged, properly investigated and responded to in line with the practice's policy. Complaints had been resolved to the satisfaction of the person raising the complaint, where possible.

In addition to the formal complaints system comments cards were available at the reception area, to enable patients to express their views and ideas about how the service could improve. We saw that a number of patients had completed these in the last 12 months.

The deputy practice manager reviewed the comments cards and complaints received each month to identify any patterns, and to ensure that the information was acted on. Staff told us that the findings of complaints were shared with the team so that lessons were learnt and that changes were made where needed. Records we looked at supported this.

Records and comments from patients and staff showed that concerns and complaints were listened to and acted on, to improve the service for patients.

Are services well-led?

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

Our findings

Leadership and culture

The practice manager and the GPs told us of the changes the practice had been through over the last two years. Staff changes and the use of temporary GPs had significantly reduced in the last 12 months following the appointment of further staff. A permanent staff team was in place to ensure that patients received consistent standards of care and service.

The practice manager and GP partners provided effective and supportive leadership. Clear lines of responsibility were in place to ensure that the service was well managed. This was evident from comments from patients, staff, observations and records we looked at.

Staff members we spoke with described the culture of the organisation as supportive and open. They also said that they felt that the service was well run. Staff praised the commitment and the approach of the practice manager to lead the service and to drive improvements.

The aims and values of the service were clearly set out, and these were shared by the practice team. Staff were committed to providing high quality, safe and effective care and services, and they were proud of their achievements as a team in the last 12 months.

Governance arrangements

Arrangements were in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. These were followed in practice.

We saw that regular practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff attended the meetings. The minutes of meetings were recorded and actions that arose from these meetings were clearly set out and reviewed, to ensure that the required changes and improvements were made to the care and services.

Staff members we spoke with were clear as to their role and responsibilities to oversee the care and services. Staff had been designated clinical lead roles for different aspects of patients care, including safeguarding, palliative care, dementia, infection control and the handling of complaints.

There was a clear commitment to develop a highly motivated and skilled team with a view to improving patient care. Discussions with staff and records showed that staff received appropriate training and development to enable them to carry out their work effectively. The practice was an accredited training practice providing work placements to doctors in training.

Systems to monitor and improve quality and improvement

We saw that effective systems were in place for gathering, recording and reviewing information about the quality and the safety of services that people received. A further administrator had been appointed to develop the information systems and the collection of data, to improve the efficiency of the practice and the monitoring of the service.

There was a clear desire within the team to improve the service for patients. Systems were in place to drive continuous improvement, and to monitor the effectiveness of the care and services provided.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles were available. These showed that essential changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Patient experience and involvement

The practice had processes in place to obtain patients views about the service and to act on their feedback to improve the service. A Patient Participation Group (PPG) was in place, which consists of a group of staff and patients who work together to discuss the work of the practice, and to identify areas for improvement. The PPG met each month and information about the group and minutes of recent meetings, were displayed in the waiting area and on the practice website. The minutes of meetings provided assurances that patients were being listened to and involved in the delivery of the service.

We spoke with two members of the PPG who told us that the practice valued their role, and had made various changes to improve the service in response to feedback from patients. For example, the number of staff answering calls in the morning had increased in response to feedback that patients were waiting too long to get through to the practice by phone.

Are services well-led?

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

The PPG conducted its own patient satisfaction survey in 2013. Patient's views were sought on a wide range of topics. The survey also contained an invitation to make suggestions for improvement. The PPG collated the survey responses and produced a report for patients and the practice. The responses showed that patients were generally satisfied with the service. The practice team had completed an action plan to address areas requiring improvement.

Staff engagement and involvement

Staff we spoke with told us they felt involved in decisions about the practice and were asked for their views about the service. They had opportunities to attend regular practice meetings to share information and to express their views.

A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it. Staff said that they felt listened to and able to raise any concerns about the service with senior staff, as they were approachable. The practice manager had an 'open door' policy to discuss any areas of concern or suggestions at any time.

Learning and improvement

Staff said that they worked well together as a team, and spoke positively about the training and development opportunities. Records showed that staff received ongoing training and development and an annual appraisal of their work.

Minutes of practice meeting showed that learning from incidents took place, which was shared with the staff team. Staff also discussed ways to improve the care and service for patients.

Records showed that accidents and incidents were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences. Minutes of practice meeting showed that learning from incidents took place, which was shared with the staff team. Staff also discussed ways to improve the care and service for patients.

Identification and management of risk

We saw that the practice had systems in place for identifying and managing risks to patients. For example, an alert system was in place on patients' computerised records, where an individual was vulnerable, at risk of abuse, on the child protection or at risk of been admitted to hospital. This alerted staff to ensure patients received appropriate support, and that relevant professionals were involved, where required.

In addition to this, the practice had systems in place to identify and manage the risks to patients in regard to the staffing levels and skill mix, the use of equipment and the cleanliness and safety of the premises.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice supported the needs of older people by:

All patients 75 years and over were allocated a named GP to offer continuity of care to ensure that their needs were being met. Patients were offered an annual review including a review of their medicines. A register was also kept of patients who had dementia to monitor their needs. Emergency health care plans were also provided for patients over 75 years to help avoid unplanned hospital admissions. to monitor their needs.

Older patients including those with palliative care needs were discussed at a monthly meeting at the practice with palliative care nurses, as to how to support and manage their needs. All clinical staff attended the meetings.

Home visits were carried out for elderly housebound patients. Vulnerable older patients were identified by a risk tool and a care plan was provided to meet their needs. Where appropriate, patients were referred to the integrated crisis response service for support.

Carers were identified and supported to care for older people. Information was available, which signpost patients and carers to support available in the community.

Shingles vaccination was offered to all patients who fit the Department of Health criteria.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice supported the needs of people with long term conditions by:

The premises were accessible and safe for people in a wheelchair or with mobility difficulties.

Patients were offered an annual health review including a review of their medication, and when clinically appropriate. Where possible, clinicians reviewed patient's long term health conditions and needs at a single appointment, to prevent them from attending various reviews.

Home visits were carried out for housebound patients. A care plan was provided for patients over 75 years with long term conditions. A named GP was usually allocated to oversee their care.

Flu and Pneumococcal vaccinations were offered to all patients with long term conditions.

Referrals to specialists and other secondary services were made in an appropriate and timely way. Health promotion advice was available and information which signposted patients to support groups and networks.

Alcohol and drug abuse services were available to patients. A smoking cessation service was also available.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice supported the needs of mothers, babies, children and young people by:

Priority was given to appointment requests for babies and young children. The mother and babies clinic had moved from the first floor to the ground floor to improve access. The baby and children's immunisations service was delivered by the practice nurse.

Antenatal care was provided. The midwife attended the practice, and GPs and midwives were able to discuss issues face to face. GPs carried out a 24 hours baby check when babies are discharged from hospital without the checks being done. They also carried out a six weeks baby check and postnatal checks for mothers.

Effective communications were in place with health visitors and school nurses to regard to concerns relating to children and babies. The GP safeguarding lead regularly met with the health visitor to discuss looked after children and children on the safeguarding register, to share information, concerns and best way to support the families. The health visitor also attended the practice each week to provide support.

GPs referred to the Diana Children's Service where appropriate, which provides care and support for children and families requiring specialist nursing care.

The practice offered contraceptive services, including advice on contraception and sexual health for teenagers. The practice also The practice also provided screening in regard to sexually transmitted infections.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice supported the needs of the working-age population and those recently retired by:

The practice provided extended opening hours on Monday from 8am to 8 pm and until 6.30pm Tuesday to Friday to enable patients to attend in an evening. Patients were also able to book non urgent appointments around their working day by telephone, on line or using the 24 hour automated booking service. A short message service (SMS) was used to invite patients for appointments and reviews. Repeat prescriptions were available online.

Patients could call and speak with a GP where appropriate if they did not wish to attend the practice. Patients could also attend blood tests in the morning or the afternoon to fit around their working day. The practice offered a 'choose and book' service for patients referred to outpatient services, which enabled them greater flexibility over when and where their test took place.

NHS health checks were offered to patients over 40 years. Systems were in place to encourage patients to attend smear tests, where appropriate. Alcohol and drug abuse services were available to patients. A smoking cessation service was also available.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice supported the needs of people in vulnerable circumstances who may have poor access to primary care by:

The practice provided extended opening hours for patients who may not attend during the day.

The staff took time to listen to patients and discussed patients in vulnerable circumstances at joint meetings with relevant health and social care professionals, to ensure they received appropriate care and support. Patients were referred to social services where appropriate for assessment of their social needs.

Carers of vulnerable patients were identified and offered support. A register was kept of patients who had a learning disability to monitor their needs. Patients were offered an annual health review including a review of their medication. They also had a named GP to offer continuity of care to ensure that their needs were being met.

Health promotion advice was available and information signposting patients to support groups and networks. Alcohol and drug abuse services were available to patients. A smoking cessation service was also available.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice supported the needs of people experiencing a mental health problem by:

Staff worked closely with local community mental health teams to ensure patients' mental health needs were reviewed, and that appropriate risk assessments and a care plan was in place. A mental health worker and counsellor held regular clinics at the practice to support patients.

A register was kept of patients with mental health problems to monitor their needs. Patients with serious mental illnesses were offered an annual review of their physical and mental health needs, including a review of their medicines. The clinical staff recognised mental health problems and managing referrals to appropriate specialist services in a timely way. Patients were enabled to access emergency care and treatment when experiencing a mental health crisis.

Health promotion advice was available and information signposting patients to support groups and networks.