Bewbush Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bewbush Medical Practice on 5 March 2015. Overall the practice is rated as good.

Bewbush Medical Practice provides services to people living in the Bewbush, Crawley area. At the time of our inspection there were approximately 7,400 patients registered at the practice with a team of two GP partners. The practice was also supported by locum GPs, nurses, healthcare assistants and a team of reception and administrative staff.

We visited the practice location at Bewbush Medical Practice, Bewbush place, Bewbush, Crawley, RH11 8XT

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, reviewed and addressed.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, 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.

Summary of findings

- Patients said they found it easy to make an appointment and urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on

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

Importantly, the provider must:

- Ensure that all staff recruitment files contain relevant information as required under the regulation, including criminal record checks via the Disclosure and Barring Service for those staff who undertake chaperone duties.
- Ensure that all significant events are recorded and that there is a greater degree of learning, including reviewing the impact upon the service provided to ensure that the event is not repeated.

In addition the provider should:

- Ensure that when needed language line is considered to help patients
- Ensure required codes for risks to children and young people on child protection plans are shown as active or non-active
- Ensure that annual appraisals record appropriate information and that staff are given a copy of their objectives.
- Ensure that staff inductions are role related and that sign off on specific learning is recorded.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Audits, significant events and complaints were reviewed and discussed. However, the practice had missed opportunities to develop further learning from these events in order to minimise repeat occurrences. The practice had failed to recognise other situations that could be recorded as significant events and used for learning. Although risks to patients who used services were assessed, the systems and processes to address these risks were not always implemented well enough to ensure patients were kept safe. For example, we noted that recruitment checks did not contain all of the required documentation for staff and that criminal record checks via the Disclosure and Barring Service had not been completed on a small number of staff who were also used as chaperones. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care.

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 compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients

Summary of findings

understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. During the inspection we witnessed caring and compassionate interactions between staff and patients. Patients had access to local groups for additional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. During the inspection we witnessed a patient requesting an urgent repeat prescription, this was ready for the patient within a couple of hours. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities.

Are services well-led?

Good

The practice was rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.The service was proactive and effectively anticipated and responded to change. There were systems in place to monitor and improve quality and identify risk. The patient participation group (PPG) was active and worked in close partnership with the practice. The practice sought feedback from staff and this had been acted upon. Staff and patients were encouraged to make suggestions for improvement and we saw evidence that suggestions were acted on. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.Staff we spoke with felt valued and were supported through regular meetings with managers, team meetings and appraisals.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were positive for conditions commonly found in older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available. The practice offered personalised care to meet the needs of the older patients in its population. It was responsive to the needs of older people, and could offer home visits. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. Appointments were available outside of school hours and the premises were suitable for children and babies. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered coil fitting. Practice staff had received safeguarding training relevant to their role. Safeguarding policies and procedures were readily available to staff. All staff were aware of child safeguarding and how to respond if they suspected abuse. The practice ensured that children needing emergency appointments would be seen on the day.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). 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. Patients were able to request a GP to telephone them instead of attending 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

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. The practice offered longer appointments for patients when required. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language and several staff members spoke various languages who could support patients if required. The practice could accommodate those patients with limited mobility or who used wheelchairs. Accessible toilet facilities were available. The practice supported patients who were registered as a carer.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Patients with severe mental health needs had care plans and new cases had rapid access to community mental health teams. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations. The practice worked with the local mental health team and consultants.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 36 comment cards which contained positive comments about the practice. We also spoke with seven patients on the day of the inspection and three members from the patient participation group (PPG).

We reviewed the results of the national patient survey from 2013 which contained the views of 125 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 95% of patients confirmed the last appointment they had booked was convenient to them. When asked about the overall experience of the surgery 90% said it was good.

The practice provided us with a copy of the practice patient survey results from 2014. Responses were received from 164 patients. The findings indicated that 95% of patients were satisfied with their visit and that 96% of patients had confidence in their GPs ability.

We spoke with seven patients on the day of the inspection and reviewed 36 comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were helpful, understanding and many described the GPs as being a 'Family' doctor. Some of the patients had been registered with the practice for a number of years and told us the practice had supported all of their family members.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff recruitment files contain relevant information as required under the regulation, including criminal records checks via the Disclosure and Barring Service for those staff who undertake chaperone duties.
- Ensure that all significant events are recorded and that there is a greater degree of learning, including reviewing the impact upon the service provided to ensure that the event is not repeated.

Action the service SHOULD take to improve

- Ensure that when needed language line is considered to help patients
- Ensure required codes for risks to children and young people on child protection plans are shown as active or non-active
- Ensure that annual appraisals record appropriate information and that staff are given a copy of their objectives.
- Ensure that staff inductions are role related and that sign off on specific learning is recorded.

Bewbush Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Practice Manager specialist.

Background to Bewbush Medical Centre

Bewbush Medical Practice offers general medical services to patients. There are approximately 7,200 registered patients.

The practice is run by two partner GPs. The practice is also supported by a practice nurse, healthcare assistants, a patient services manager, a reception manager, a team of receptionists and administrative staff, an assistant practice manager and a practice manager.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from the location:

Bewbush Medical Practice, Bewbush Place, Bewbush, Crawley, RH11 8XT

There are arrangements for patients to access care from an Out of Hours provider through NHS 111.

The practice population has a significantly lower number of patients between 55-85 years of age than the national and local CCG average. Patients aged 0 and 39 were above average, with a significant higher proportion 0-4 year old and 20-34 year olds than the national average. There are fewer patients with a long standing health condition and the percentage of registered patients suffering deprivation (affecting both adults and children) is average for England.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and

Detailed findings

the Crawley Clinical Commissioning Group (CCG). We carried out an announced visit on 5 March 2015. During our visit we spoke with a range of staff, including GPs, nurses and administration staff.

We observed staff and patients interaction and talked with seven patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 36 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 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 and we were able to review these. 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. Significant events were discussed at a monthly senior staff members meeting. Although we saw there was learning from events these had not always been reviewed fully. For example, we saw an event had been raised in response to the nurse practitioner not calling back a patient with a sick child for advice. The practice had taken on board the concerns raised and had recorded learning from the event. However, it had failed to investigate the full situation and recognise the follow on concerns from this event. We did not see learning passed to reception staff as to what to do if this situation arose again. We asked staff about urgent appointments for sick children attending the practice. They told us they would let the GP know via instant messenger so that the GP could see the child as soon as possible.

The practice showed us the system used to manage and monitor incidents. We saw records for incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, the practice had received the results of tests completed for a patient. The results were scanned on to the patient record but had not been forwarded to the GP. The results indicated that the patient needed to be referred and this was delayed due to the GP not seeing the results. The patient was apologised to and an explanation given. The incident was discussed and the scanning policy was changed to reflect the learning from this incident in order to prevent the same incident from happening again.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings and if needed during one to one meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level 3 safeguarding children training). Staff could demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding leads were and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible in.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All staff, including reception and administration staff could be asked to be a chaperone. We noted that not all staff undertaking these duties had received a criminal records check through the Disclosure and Barring Service. All reception and administration staff had received training to fulfil this role. We saw there were posters on display within the clinical rooms and waiting area which displayed information for patients.

Requires improvement

Are services safe?

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. However, we noted there was no record if the protection plan was active or non-active. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

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.

The practice had processes 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. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

There were comprehensive medicines management policies in place. GPs took ownership of their own patient repeat prescription requests and patient medicines reviews were organised in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Vaccines were administered by the nurse and the healthcare assistant using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives and evidence that the nurse and the healthcare assistant had received appropriate training to administer vaccines.

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.

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice carried out audits and that any improvements identified for action were completed in a timely manner.

An infection control policy and supporting procedures were available for staff to refer to including a policy for needle stick injury. This enabled staff 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. Staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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 scale and blood pressure measuring devices.

Staffing and recruitment

Requires improvement

Are services safe?

Records we looked at did not all contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, files did not contain proof of identification, including proof of address or photographic identification, and some administration staff who were used as chaperones did not have criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 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. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we viewed meeting minutes where a significant event had been discussed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Senior staff members had access to the continuity plan out of normal working hours and staff told us they were able to contact senior staff members if the continuity plan needed to be used. For example, if staff were unable to attend the practice due to snow.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the fire alarm was checked weekly and that staff practised fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral into secondary care. For example, suspected cancers were referred and seen within two weeks.

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

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, clinical reviews and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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). For example, we saw an audit in relation to patients having regular blood tests while being prescribed a particular medicine. The practice had completed an original audit where results showed that 10 out of 16 patients were receiving regular blood testing. The most recent audits finding showed that 18 out of 20 patients were being regular testing. We saw the two patients who did not have regular blood tests were reviewed by the GPs.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 92% of patients with diabetes had a record of retinal screening in the preceding 12 months. We also noted that 90% of patients diagnosed with asthma had an asthma review in the preceding 12 months and 96% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional, including an assessment of breathlessness in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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 IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert,

Good

Are services effective?

(for example, treatment is effective)

the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. Patients were also highlighted on the practice computer system so that their care could be prioritised.

Effective staffing

We looked through training records for staff. Most staff had completed training in basic life support, fire awareness and safeguarding children.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. We noted that information recorded in appraisal notes did not always reflect the full discussions had. Staff we spoke with had not always received a copy of their appraisal or objectives. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the healthcare assistant informed us that previous to this role they were part of the reception team. They told us the practice had encouraged them to take on further training and their final aim was to become a practice nurse.

The practice nurse was expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of 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. Relevant staff were aware of their responsibilities 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 had very few patients who had palliative care needs. They told us that meetings were held to discuss the needs of complex patients when required. For example, palliative care would be discussed with the local hospice for those patients with end of life care needs.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used a referral system for patients requiring specialist treatment and dedicated staff were used to ensure referrals were done in a timely manner. The GPs spoke with patients as to where they would like their consultation to be before organising the referral.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff we spoke with highlighted how patients should be supported to make their own decisions and how this would be documented in the medical notes. We saw evidence that the GPs and management team had received training for the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties (DoLs) in January 2015 and that non-clinical staff were booked in for training in March 2015

Good

Are services effective?

(for example, treatment is effective)

Care plans were used to support patients to make decisions regarding their care. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The GPs demonstrated a clear understanding of Gillick competencies. However, the nurse told us she was unsure of her own understanding. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. We noted there was a consent policy for staff to refer to. The policy referred to implied and expressed consent and how patients have the right to refuse consent at any time.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic offering smoking cessation advice to smokers and reminding patients who were overdue cervical screenings.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice had identified the smoking status of 85% of patients over the age of 16 and we noted that 78% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 99% of children aged below 24 months had received their mumps, measles and rubella vaccination. The practice's performance for cervical smear uptake was 74%, which was slightly below other practices nationally. The practice was aware of this and understood that there uptake rate had reduced due to the practice nurse leaving. There was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 164 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them and 86% saying the GP gave them enough time.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients said they felt the practice offered an excellent service and staff were friendly, considerate and caring. They said staff treated them with dignity and respect. Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards and all were positive about the service experienced

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. Patients were able to book in using an electronic booking in system which also allowed for a patient confidentiality. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view.

Care planning and involvement in decisions about care and treatment

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 showed 83% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local clinical commissioning group area.

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

Staff told us that translation services were available for patients who did not have English as a first language. However, some staff had not considered using this to help with patients whose understanding of English may have been limited.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 86% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 91% of patients said the nurses were also good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

Notices in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown an information board in the waiting area which contained information for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their GP would contact them. Staff could also arrange a patient consultation at a flexible time and would give them advice on how to find support services.

Good

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had two male GP's and understood that some patients would prefer to see a female GP. The practice had ensured that they employed a female locum GP for a few sessions a week in order to facilitate any specific requests.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had changed the phone number for the practice from a premium number to a local number to reduce the burden of cost for patients. Patients had also expressed concerns for patient privacy whilst booking in. The practice had installed a barrier system, so that only one patient could book in with reception to allow for greater privacy. The practice had also installed a booking in computer screen for patients to use.

Patients with long term condition had their health reviewed in an annual review. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health.

Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up. Post natal and six week check were provided and the midwife held a full day clinic each week at the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had a number of patients whose first language was not English. Some practice staff were able to speak a variety of languages that could also support patients if required. We noted that the booking in system was in several different languages to aid people when booking in. Staff knew how to access language translation services if these were required. The practice website also had the functionality to translate the practice information into 90 different languages. We noted that staff had received equality and diversity training and that there was a policy to support staff. The practice had a hearing loop for those patients with hearing impairments.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was situated on the ground floor of a purpose built building. We noted patients had access to the front entrance of the practice via a slope and doors which had an automatic opening mechanism. However, the next internal door needed to be opened manually. Patients with restricted mobility could enter the practice but did not have level access to the reception desk. Waiting areas were accessible for patients who used wheelchairs and parents with prams. Accessible toilet facilities including baby changing facilities were available for all patients attending the practice. We noted that the door leading to the main corridor from the waiting room may not have been wide enough for some motorised wheelchairs. However, patients were able to use the fire exit to the side of the building which was slightly wider and had a sloping entrance.

Staff we spoke with told us they felt the building was no longer able to accommodate the needs of their growing patient list. The practice manager and a partner GP explained that suitable premises had been located and were waiting for final decisions to be made. Patients we spoke with were aware of the new move and supported the need for larger, more accessible premises.

Access to the service

The surgery was open Monday to Friday 8:30am to 6pm. Appointments were available from 8:30am until 11:30 and from 2pm to 5:30pm. There was a late evening surgery on a Monday from 6.30pm to 8:00pm. A small number of appointments were able to be booked in advance with majority of appointments available on the day for patients who called.

Comprehensive information was available to patients about appointments on the practice website and through a practice leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. All the patients we spoke with on the day told us they had been able to get appointments at a time convenient to them. Staff told us longer appointments were also available for patients who needed them and those with long-term conditions.

Data from the national patient survey indicated that 95% of respondents said the last appointment they got was convenient**.** On the day of inspection we asked staff when the next available appointment would be see a GP and a cervical screening appointment with the nurse. We were given an appointment for the same day for both requests.

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.

We saw that information was available to help patients understand the complaints system and was displayed in the waiting room and the practice had a leaflet available. Patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, none of the patients we spoke with had ever needed to make a complaint about the practice and all said they would ask to speak with a senior member of staff and felt they would be listened to.

We looked at four complaints received in the last 12 months and found these were handled, in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

The practice reviewed complaints to detect themes or trends, however this was not always documented. We saw that lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a no blame culture in the practice and felt that senior staff members were always available to talk with. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included providing personal, high quality general practice care to individuals and families where the patient comes first. The practices mission statement was 'to provide an appropriate and rewarding experience for our patients whenever they need our support'.

We spoke with 15 members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Many of the staff had worked at the practice for a number of years and spoke very positively about the practice. They told us there was good team work and they were actively supported to provide good care for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at some of these policies and procedures and found these were up to date and contained relevant information for staff to follow. This included whistleblowing, complaints, consent, chaperoning and safeguarding children.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a partner GP was the lead for safeguarding. We spoke with 15 members of staff 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 used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, coil fittings, cervical screening and reviewing medicines used for abnormal heart rhythms.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us a variety of risk assessments that had been carried out. For example, we saw that risks had been accessed for lone working, manual handling, fire and infection control.

The practice held monthly meetings with the GPs, nurse and senior team members where discussions were had for performance, quality and risks. Clinical audits and significant events were also discussed at these meetings. Staff we spoke with told us they attended meetings which enabled them to keep up to date with practice developments and facilitated communication between the GPs and the staff team, however these were not recorded.

Leadership, openness and transparency

The GP partners held monthly meetings with the senior members of staff where discussions were had on management issues including such as Quality Outcomes Framework (QOF) data and significant events.

The practice had a business development plan which set out the practice's objectives for patients and the practice over the next three years. For example, the plan indicated the continued importance of looking at the practices performance (including patient comments) and ensuring a good skill mix of staff with job satisfaction and regular training. One of the GP partners was planning to retire within three years. We saw evidence that discussions had taken place for succession planning and a new GP was in the process of being employed with future plans to become a partner of the practice.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time not just at team meetings. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

The practice manager was responsible for human resource policies and procedures. We were shown the electronic staff handbook that was available to all staff. This included

Are services well-led?

Good

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

sections on equality and harassment disciplinary procedures, and management of sickness, which were in place to support staff. 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 gathered feedback from patients through patient surveys, comment cards and complaints received. Staff we spoke with told us that patients had complained about the cost of the 0845 number when calling the practice for appointments. The practice had changed their number to a local number to ensure patients were not being charged more than necessary to call the practice.

The practice had a patient participation group (PPG) which worked in partnership with the practice. We were able to speak with three members of the PPG on the day of the inspection. They told us that the PPG meet every three months with the practice manager and a partner GP. They supported and advised the practice in areas such as, the on-line booking system, extended hours and creating an action plan from the patient survey. The practice manager showed us the analysis of the surveys completed and the reports and action plans agreed with the PPG were available on the practice website for patients to see.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff we spoke with gave us an example where their suggestion had been acted upon. They told us there had been a delay in receiving forms for blood test. They had suggested that blood test forms were printed out by the receptionist as soon as this was booked for a patient. We were told by staff this new system was working well. Staff told us they attended staff meetings and felt confident in raising concerns or questions. Meetings allowed for discussions in relation to changes to procedures, clinical practice, and staff cover arrangements. However, these meetings were not recorded.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with told us they would have no concerns in using the policy to protect patients if they thought it necessary.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. We noted that the clinical staff had received their appraisals and the reception and administration team had theirs planned for March 2015. Staff told us that the practice was very supportive of training and that they had regular training either organised with the local clinical commissioning group or by the practice. We looked through training records for staff and saw that most staff had completed training in basic life support, fire awareness, health and safety, child protection and safeguarding vulnerable adults. A staff member told us they were being supported by the practice to attain further qualifications in their field of work.

All staff received an induction when they first started work. Staff we spoke with told us they were given a buddy to work with and had one to one meetings with a senior staff member to discuss their progress. However, we noted that induction records and learning required were not role specific. For example, roles we might expect the nurse to be signed off as being competent in during their induction were not evidenced.

The practice had completed reviews of significant events and other incidents and shared this information with some staff members. However, there needed to be a wider learning from some of the events to ensure that all staff were aware of how to prevent a repeat incident. Discussions were had to ensure the practice improved outcomes for patients and staff but we noted these were not always recorded. For example, staff told us of an incident of person collapsing outside of the surgery at the local shops. Practice staff had attended the emergency and administered basic life support. This has not been recorded as a significant event but had been discussed amongst the staff members. An opportunity for learning from a serious incident and supporting staff thereafter was hence missed.

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 We found that the registered provider did not ensure that information regarding proof of identity including photograph identification was present in recruitment files. Staff who required a criminal check through the Disclosure and Barring Service were not always completed for those staff who acted as chaperones. This was in breach of regulation 21 (a) (i) (iii) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19(1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 We found that the provider had failed to ensure that patients were protected against the risk of unsafe or inappropriate care and treatment due to not identifying or fully assessing risks. The provider did not record all potential significant events and in some instances did not assess the full impact of significant events upon the service provided. This was in breach of regulation 10 (1) (b) (2)(c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.