Bury Road Surgery

Quality Report

Gosport War Memorial Hospital
Bury Road
Gosport
Hampshire
PO12 3PW
Tel: 02392 580363
Website: www.buryroadsurgery.co.uk

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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 a comprehensive inspection of Bury Road Surgery, Gosport War Memorial Hospital, Bury Road, Gosport, Hampshire, PO12 3PW on 18 December 2014.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

- Patients were complimentary about the care and support they received from staff.
- Staff told us they were committed to providing a service that put patients first.
- The practice worked with other health and social care professionals and organisations to ensure that their patients received the most effective support and treatment.
- Staff were trained in and aware of their responsibilities for safeguarding of vulnerable adults and children. There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the practice.
- Patients told us they could always get an emergency appointment and waiting time for routine appointments was satisfactory.
- One of the GPs had specific training for assessing capacity and had qualified to a higher level of the Mental Health Act 1983.

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

The provider must:

Summary of findings

- Make improvements in relation to monitoring medication fridges

The provider should:

- Carry out audits in relation to infection control.
- Carry out formal Mental Capacity Act training for staff.

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 must make improvements.

Entry and exit to and from the reception and waiting areas were all on one level. There was a clean and tidy waiting area.

Staff we spoke with were trained in and aware of their responsibilities for safeguarding of vulnerable adults and children. There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the practice.

The practice had suitable arrangements in place for dealing with emergency situations and we saw policies in relation to reacting to any interruption to the service provided.

Vaccines, medicines and prescriptions kept on the premises were stored suitably and securely. There were suitable systems for the receipt, storage, record and administration of vaccines.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There were areas of concern found in infection control and medicine management. These concerns were in relation to monitoring medication fridges and audits in relation to infection control.

Are services effective?

Good

The practice is rated as good for providing effective services.

There were systems in place to ensure there were sufficient staff to meet patient needs. Patient needs were assessed and care and treatment was delivered in line with current legislation and best practice.

There were sufficient staff who received regular training and on-going support through an effective appraisal system.

The practice had systems and processes in place to make sure that standards of care were effectively monitored and maintained.

The practice worked with other health and social care professionals and organisations to ensure that their patients received the most effective support and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

Patients we spoke with told us that they were well informed about their care and treatment. We observed patients being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient privacy, dignity and confidentiality when registering or booking in patients.

All the patients we spoke with, and the comments we received were complimentary of the care and service that staff provided.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice understood the needs of their patient population and this was reflected in the setup of the practice environment and systems used to meet some of the needs of their patients.

Patients told us they could always get an emergency appointment and waiting time for routine appointments was satisfactory.

The practice obtained and acted on patient's feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

There was a clear leadership structure and staff felt supported by management and a culture of openness and honesty was encouraged.

The staff worked as a team and ensured that patients received a high standard of care. Staff had received inductions, regular performance reviews and attended staff meetings.

Risks to the safe and effective delivery of services were assessed and addressed in a timely manner. A suitable business continuity plan was in place. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions.

Patients in this population group received a safe, effective care which was based on national guidance. Care was tailored to patient needs, there was a multi-disciplinary input and was reviewed regularly.

The practice provided regular clinics for patients with diabetes, respiratory and cardiac conditions. The practice had a diabetes nurse specialist and three GPs who were had received training and provided diabetic care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice followed national protocols and staff were aware of their responsibilities and the various legal requirements in the delivery of care to patients in this population group. They worked with other health and social care providers to provide safe care.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young patients were treated in an appropriate way and recognised as individuals. We were provided with good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working age patients (including those recently retired and students).

Summary of findings

There was an appropriate system of receiving and responding to concerns and feedback from patients in this group who had found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group whose circumstances may make them vulnerable.

There was evidence of good multidisciplinary working with involvement of other health and social care workers. Staff were trained on safeguarding vulnerable adults and child protection.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including patients with dementia).

One of the GPs had specific training for assessing capacity and had qualified to a higher level, section 12(2) of the Mental Health Act 1983.

The practice ensured that good quality care was provided for patients with poor mental health. The practice had a nominated lead for linking with other health professionals and community teams to ensure a safe, effective and co-ordinated service. The practice offered proactive, personalised care that met the needs of the older patients in its population and had a range of enhanced services, for example in dementia. Data showed that this practice had a better than national average score for dementia diagnosis rate adjusted by the number of patients in residential care homes.

Summary of findings

What people who use the service say

During our visit we spoke with six patients, including one member of the patient participation group (PPG) and reviewed eight comments cards from patients who had visited the practice in the previous two weeks. The majority of the feedback we received was positive although one comment was negative about the time spent waiting at an appointment to see the GP. Patients were complimentary about the practice staff team and the care and treatment they received. Patients told us that they were not rushed, that the appointments system was effective and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Areas for improvement

Action the service MUST take to improve

- Make improvements in relation to monitoring medication fridges .

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

Action the service SHOULD take to improve

- Carry out audits in relation to infection control.
- Carry out formal Mental Capacity Act training for staff.

Bury Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP, a specialist advisor practice manager, a specialist advisor nurse and an expert by experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Bury Road Surgery

Bury Road Surgery, Gosport War Memorial Hospital, Bury Road, Gosport, Hampshire, PO12 3PW is a purpose built surgery located within the Gosport war memorial hospital. The practice has been at this location since 2012.

The practice at the time of our visit had three GPs, two full time male partners and a salaried female GP. The practice has around 4,000 patients. All the consulting rooms and waiting areas afforded good disabled access. The practice manager started at the practice in July 2014 and there were two practice nurses one health care assistant and ten administration and reception staff.

Out of Hours urgent medical care was provided when the practice was closed from 6:30 pm to 8 am, Monday to Friday and all day and night at the weekends and public holidays. Since 1st April 2013 the practice had extended hours are as follows: Monday each week 6:30pm to 7:30pm. Two GP's covered these sessions. The sessions were for pre-booked and urgent appointments.

This practice had been previously inspected by the CQC in January 2014.This was a routine inspection to check that essential standards of quality and safety were being met. The practice was found to be meeting the required standards in six outcomes those were; respecting and involving patients who used services, care and welfare of people who used services, safeguarding patients who used the services from abuse, requirements relating to workers, assessing and monitoring the quality of service provision and complaints.

This practice was placed in Band 6 by CQC Intelligent Monitoring. The CQC has categorised GP practices into one of six summary bands, with band 1 representing highest risk and band 6 lowest. These bands have been assigned based on the proportion of indicators that have been identified as “risk” or “elevated risk”.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the practice to send us

Detailed findings

information about themselves, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 18 December 2014.

During our visit we spoke with a range of staff including GPs, practice nurses, practice manager, administration staff and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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)

Requires improvement

Are services safe?

Our findings

Safe track record

The registered manager and senior GP worked closely with the practice manager on governance at the practice and monitored incidents, near misses and significant events. The practice GPs met on a regular basis to discuss safety of patients and safe care of patients. Any learning points were discussed openly and any actions were taken and systems changes were made where appropriate. We discussed audits and saw examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it had made a difference or not. We saw evidence of reflection at the end of the full cycle, regardless of whether the desired change was achieved not. An example seen was an audit of impaired glucose intolerance tests. This had identified an issue with the coding. There had been agreed changes and a further audit was set for October 2105. The results were discussed and shared with the clinical staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where systems within the practice had been changed to minimise further risks. An example seen was when medication was prescribed but not issued by a pharmacy so the patient was not taking the correct medication. The decision not to dispense was made by the pharmacy. The incident was discussed and the action was that the pharmacy should issue as prescribed and, if they have a query, they should discuss with GP. A letter was sent to pharmacy requesting this action be adopted.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in specific level three training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Examples were given by staff of safeguarding concerns they had raised. Any case of concern was discussed during the Monday clinical meetings.

Staff told us that they understood what "whistleblowing" was. They were able to explain the actions they would take if they needed to use this process and felt that if required they would have confidence to start the process.

The practice offered patients the services of a chaperone during examinations if required. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw that details of this service were displayed around the practice building for patients to read and staff told that this service was offered to patients.

Medicines management

The practice maintained a log of fridge temperature checks, daily during practice opening hours. Not all staff responsible for checking the temperatures were aware of protocols to follow if the fridge temperature was not maintained suitably. Vaccines were kept in two temperature controlled medication refrigerators. We saw that on 14 occasions recorded within the last two months the temperature went above eight degrees Celsius. The temperature should be maintained between two degrees Celsius and eight degrees Celsius. No apparent action had been taken on these occasions. We saw that the medicines cupboard and the vaccines refrigerator were securely locked although on checking we found that there were expired patient specific injectable medicines in the fridge. There were four unmonitored controlled medicine, expired vials locked in the controlled drugs safe.

We checked the emergency medicines kit and found that all the medicines were in date. There was a log maintained with the expiry dates of all the medicines available in the kit. All the vaccines that we checked were within their expiry date.

There was a GP lead for prescribing and regular audits and reviews of the prescriptions for patients with long term conditions were undertaken using the data collection tools on the practice computer systems.

Requires improvement

Are services safe?

Prescription pads were securely kept in a locked cupboard within a designated area of the practice.

Cleanliness and infection control

There was no designated infection control lead that was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. We found that there had not been any recent structured infection control audit to allow documented evidence of risk.

Patients we spoke with commented positively about the standard of cleanliness at the practice. The premises and especially the nurses' treatment room appeared clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with displayed information and clean privacy curtains, sharps box and foot operated waste bins. We spoke with staff who clearly described the procedures in place to maintain a clean and safe working environment. Infection control training had taken place within the last 12 months and all the relevant staff had attended this training.

Hand washing guides were available above all sinks both in clinical and patient areas. There was a good supply of bacterial soap pump dispensers and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. Clinical waste was disposed of appropriately and after being removed from the practice by cleaning staff as part of the overall cleaning practices of the hospital in which the practice was located.

Equipment

The practice had appropriate equipment and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise. The practice had an Automated External Defibrillator (AED) an AED is used in the emergency treatment of a person having a cardiac arrest.

Regular checks were undertaken on the equipment used in the practice. Examples of calibration checks of equipment within the last 12 months by a contactor were seen. Continual risk assessing took place in the different areas of the surgery and we saw evidence of the assessments in the health and safety file.

Staffing and recruitment

The practice had a suitable process for the recruitment of all staff. The practice carried out pre-employment checks which included appropriate references, and where required criminal record checks, such as using the Disclosure and Barring Service. Newly appointed staff received an induction which included explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

Staff told us that they had worked at the practice for a number of years and some had moved with the practice to the new building. The practice manager and GPs we spoke with told us that they felt the stable and experienced work force provided a safe environment for their patients. Staff at this practice worked as a team to cover the practice opening hours and would adjust their hours to cover any sickness or annual leave.

Monitoring safety and responding to risk

Risk assessments were carried out for safety in the practice and emergency procedures were carried out such as fire alarm testing and evacuation procedures. Changes to risk were monitored and responded to as and when required.

The practice carried out regular fire drills to ensure fire safety. Continual risk assessments of the surgery and evidence of the assessments was found in the Health and Safety file.

Staff had taken part in emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Equipment testing and fire extinguisher testing were up to date. An up to date and resolved accident book was present.

The practice was located inside a hospital and we were told that assessments in relation to legionella were conducted by the hospital for the whole of the building.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency drugs and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service.

Requires improvement

Are services safe?

As the practice was located inside a local hospital the provider worked with the hospital policies on the arrangements to deal with emergencies and major incidents effecting the hospital.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had regular meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of people.

The meetings covered various clinical issues, an example seen was in regards to individualising new patient care; all new patients were offered new patient checks and patients over 75 years of age had their needs assessed. Chronic disease management appointments were offered as appropriate, as well as GP appointments when required.

Management, monitoring and improving outcomes for people

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. The practice carried out regular clinical audits to ensure the treatment they offered patients was in line with relevant guidance. There was evidence of learning from the audit process.

The practice used the Quality and Outcome Framework (QOF) to improve care for example, by exploring clinical changes for conditions such as diabetes. QOF was used to monitor the quality of services provided. The practice used to the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities. That they had a complete register of available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed. The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the QOF disease registers were contacted and recalled at suitable intervals.

The practice showed us documentary evidence of updating care pathways in accordance with NICE for example a chronic obstructive pulmonary disease algorithm in the treatment rooms on laminated signs.

Effective staffing

Staff received appropriate support and professional development. The practice had identified training modules to be completed by staff which included safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

The staff told us they had received this training and how much they enjoyed their variety of work. Staff we spoke with all told us that they felt well supported by their colleagues and the practice manager. They said they had been supported to attend training courses to help them in their professional development and that there was a culture of openness and communication at the practice and they felt comfortable to raise concerns or discuss ideas.

All the GPs were appraised annually and were awaiting revalidation; the process by which GPs demonstrated they were up to date and fit to practise.

The practice tried not to employ locum GPs and each GP covered annual leave and sickness. The practice felt that this provided a continuity of care for the patients.

Working with colleagues and other services

The provider worked in co-operation with other services and there was evidence of good multi-disciplinary team working. An example seen was in regards to a patient's medical and social needs, they were assessed and the practice assisted the patient to receive assistance from social services and mental health teams who were now monitoring the patient. The practice also was able to facilitate a caring agency to respond to the patient.

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement of other social and healthcare professionals especially in the care of the elderly.

The practice held regular meetings every three months with a hospice team district nurses to discuss patients and one of the GPs was an end of life lead.

A community midwife worked with the GPs to provide maternity services. She held her own ante-natal clinics on Wednesday afternoon every other week. She was available to offer help and advice, including pre-conception advice.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice lead on information governance and the Caldicott Guardian explained that staff were given training and discussed confidentiality. Staff we spoke with were able to explain the training they had received about information sharing. An example given was that when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the clinical staff.

Where required information was shared in a responsible and comprehensive way. An example seen was that care plans for vulnerable were shared and uploaded to ambulance and Out of Hours service.

Consent to care and treatment

Staff were aware of how to obtain patients consent for treatment and care and could describe actions that they would take. However, they had not received any formal training on the Mental Capacity Act (2005), although they could demonstrate the principles, and knew about use of advocates when needed. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

We spoke with nurses who demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and a patient we spoke with confirmed that they understood about giving consent and did not feel pressured into agreeing to treatment.

When the GP or the nurses deemed the patient did not have capacity to consent then they discussed the matter with the next of kin, carer as well as fellow professionals. One of the GPs had received specific training for assessing and recording capacity decisions.

Health promotion and prevention

The practice ensured that where applicable people received appropriate support and advice for health promotion. Information available to patients was effective. We saw examples of health promotion as the practice offered well woman and well man clinics.

Notices were visible. An information leaflet rack was full and up to date with a good variety of information.

Advice was available on the practice web site on healthy eating, weight reduction, sensible drinking, exercise, smoking cessation, diabetes, asthma, hypertension, coronary heart disease, thyroid and chronic obstructive pulmonary disease.

The practice had procedures for monitoring patients with diabetes, asthma, hypertension, coronary heart disease, under-active thyroid and chronic obstructive pulmonary diseases. Patients were invited for periodic checks to assess control, check their general health and review their medication.

Child immunisations were called regularly and non-attenders were notified to the Health visiting service. The Practice had achieved above 90% of its immunisation cohort.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet. There were no queues at the desk, and patients were directed swiftly. The reception was accessible to patients with disabilities with lower desk height for wheelchair users. There were signs that asked for patients to respect the privacy of other patients. The practice had a room set aside for patients to use if they required further privacy to discuss any matter.

Although the receptionist took phone calls at the desk, confidentiality was maintained as at no time did they mention any name or diagnosis or treatment. The practice switchboard was located in a separate room to the reception desk.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five 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.

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 observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. They practice ensured that the out of hours service was aware of any information regarding their patients' end of life needs. We saw that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

We spoke with GPs who told us that patients were involved in deciding what care or treatment they received. They told us they achieved this by giving patients information about the types of care or treatments available and making clinical recommendations. This meant that patients were able to make informed decisions and demonstrated that the practice took account of patients' needs and wishes.

All the GPs told us that patients were treated with care and respect and involved in all decisions about their care. The practice used a simple format in consultations to ensure that each patient was treated consistently. Connect with patient, listen to patient, explain to patient, find a course of treatment acceptable to both parties, reflect and repeat the treatment.

Patients were able to choose the local hospital where they wished to have further treatment. GPs told us they discussed the different hospital options with patients in order to support them to make an informed decision and make choices about where they wanted to have further treatment.

All the patients we spoke to told us that GPs and other medical staff took time to listen to them and had fully discussed their treatment options. The practice told us they used a variety of methods to ensure patients were informed about their medical issue in a way they understood. For example the practice printed information about a range of health conditions and also accessed online patient leaflets which they could print off for their patient.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

We were told that caring for carers was a practice policy and we saw letters of appreciation from patients thanking the practice for the support they offered.

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 people'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 was situated in purpose built premises which were compliant with legal access requirements for disabled patients. All consulting rooms were on the ground floor. The entrance to the practice was shared with the entrance to the hospital and had automatic doors and made easy access for patients who had reduced mobility. The practice had wide corridors with wider doors and there were toilet facilities for disabled patients and parents with children. The practice also had a quiet room in which patients could sit if required.

The practice worked with a patient participation group (PPG) to produce a practice survey for the wider practice population. The patient survey undertaken in 2013 showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice in the two weeks before our visit. The PPG met quarterly with the GPs and an example of suggestions made by the group was a suggestion box in the waiting area.

Travel Immunisations advice was provided on completion of a travel questionnaire. The practice nurses administered these as directed by the advice supplied by the NHS.

Patient counselling services were available, referral being through the GPs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to online and telephone translation services for patients whose first language was not English.

The premises and services had been adapted to meet the needs of people with disabilities. The practice had accessible toilet facilities in the waiting room and had adapted to reception area to suit the needs of patients with disabilities.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The telephone lines at the practice opened at 08:00am to 6:30pm each day and although the practice closed between 1pm and 2pm the telephones lines remained open.

The practice was open on Monday from 08:30am to 1pm and 2pm to 7.30pm and on Tuesday to Friday from 08:30am to 1pm and 2pm to 6:30pm. The practice was closed on Saturday and Sunday.

The practice provided extended hours on Monday evening and had two GP's covering these sessions. The sessions were for pre-booked and urgent appointments.

The practice nurses saw people by appointment for nursing matters such as vaccinations, cervical smears, suture removal, ear syringing and dressings.

Patients could make routine appointment to see a GP during normal surgery hours by telephoning the practice. Each appointment was for one patient for a 10 minute consultation. If the patient felt they needed longer they could book a double appointment (20 mins).

Urgent appointments were released each morning between 8.00am and 11.00am. If required patients were asked to telephone the surgery between 8.00arn and 8.30am.

The practice operated a triage system for on the day requests. Patients were asked to call the practice and following a brief conversation with the receptionist, were added to the triage list. The duty GP worked through that list by telephoning each patient. The outcome could be one of the following:

1. The GP asked the patient to attend in that day at an agreed a time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

2.The GP consulted with patient over the phone and gave advice, possibly preparing a prescription for collection

3. The GP asked patient to make an appointment on a future date either with a GP or another member of the clinical team, such as a practice nurse.

The practice found that using a triage system allowed GPs to consult with more patients and in a way that was often more convenient to the patient by avoiding the need to go to the surgery when it was not required.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice.

For older people and people with long-term conditions longer appointments were made available when needed. Appointments were available outside of school hours for children and young people.

People whose circumstances made them vulnerable were supported to attend the practice and the practice was working to understand the needs of the most vulnerable in the practice population. Patients experiencing poor mental health within the practice population were offered longer appointments for those that needed them.

Listening and learning from concerns and complaints

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

Complaints were responded in a timely manner and audits were undertaken regularly to review the working procedures and practices which were amended where applicable. The complaints had been analysed to try and ensure that there were no repeats. The practice manager used the information to create learning points where required and these were fed back to staff for information.

The practice had a culture of openness and learning. Staff told us that they felt confident in raising issues and concerns. We saw that incidents were reported promptly and analysed. All complaints are discussed the at a Monday lunchtime meeting with the clinical staff, evidence of this was seen in the minutes from the meetings.

The complaints leaflet was available on the reception desk and contained information on referring the complaint to the Parliamentary Ombudsman.

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 practice had a clear vision and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to our patients. These were communicated to patients in the waiting area and on the practice website. Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care.

Staff told us effective communication was a strength in this practice, and that there was a caring ethos of putting patients first that resulted from the GP leadership. Staff told us the practice had an open and equal way of working to ensure that everybody felt part of the team.

The practice manager had daily "ad hoc" meetings with the GPs and formal weekly meetings. There were staff meetings every three months. The practice tried not to employ locum GPs and each GP covered annual leave and sickness. The practice felt that this provided a continuity of care for the patients. The practice considered staff wellbeing and was trying to provide a positive working environment although was preparing for the future.

Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at governance meetings and action plans were produced to maintain or improve outcomes.

Partner GPs and staff had areas of responsibility, such as, prescribing or safeguarding it was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

We reviewed a number of policies, for example, complaints handling protocol and recruitment policy in place to support staff. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

We saw good working relationships amongst staff and an ethos of team working.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

The practice gathered feedback from patients through: patient surveys, comment cards and complaints received. For example, the practice worked with a patient participation group to produce a practice survey for the wider practice population. The patient survey undertaken in 2013 showed that patients were happy with the service and that it met their needs.

The practice also 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 told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Clinical audits were instigated from within the practice or from safety alerts received. We looked at several clinical audits and found they were well documented however not all demonstrated a full audit cycle. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: A fridge which was used to store medicines and vaccinations showed that recorded temperatures rose above the recommended range on a number of occasions. This may have affected the medicines stored in it. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.