Tettenhall Medical Practice

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

We inspected Tettenhall Medical Practice, on 1 December 2014 as part of a comprehensive inspection. There is a branch surgery which is known as Wood Road Health Centre, This inspection focused on the main site and we did not visit the branch.

We found that the practice to be good in, responsive, caring, and well-led. However, we found the practice required improvement to the deliver safe and effective care. We rated the practice overall as requiring improvement.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service. However, some systems were not robust as emergency medicines in GPs bags were out of date.
- The practice did not have effective procedures in place that ensured overall care and treatment was delivered in line with appropriate standards. Consent was not routinely sought for minor surgical procedures.
- Patients were treated with dignity and respect. Patients spoke very positively of their experiences and of the care and treatment provided by staff.
- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups including those with long term conditions.
- We found that the service was well led with policies and procedures in place to support the running of the practice.

Areas of practice where the provider needs to make improvements are:

The provider must:

- Arrangements must be in place to ensure that emergency medicines are available and in date.

In addition the practice should:

Summary of findings

- The practice should ensure suitable arrangements are in place for obtaining, and acting in accordance with, the consent of people who use the service in relation to the care and treatment provided for them.
- Develop a protocol to record actions taken in response to medical alerts.
- Ensure staff are aware of the business continuity plan.
- Ensure prescription pads are always stored securely according to NHS Protect August 2013 Guidance.
- Ensure all staff are aware of the Mental Capacity Act (2005).

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 service is rated as required improvement in respect to safe. There were systems in place to ensure patients received a safe service however, some of these were not always robust. We identified emergency medicines that were out of date in two doctor's bags. There was no documentation in place to demonstrate that checks had been undertaken on emergency medical equipment.

Are services effective?

Good

The service is rated good for effective. There was evidence that the practice had joint working arrangements with other health care professionals and services. Effective arrangements were in place to identify, review and monitor patients with long term conditions and those in high risk groups. Most staff had received core and mandatory training appropriate to the practice and their roles and there was evidence of staff appraisals to support learning and development. Where staff had required training this was arranged. There were inconsistencies in regards to obtaining and documenting consent for minor surgery such as excisions.

Are services caring?

Good

The practice is rated good for caring. Patients said staff were caring and that their privacy and dignity was respected during consultations. Translation services were available to people whose first language was not English.

There were arrangements in place to provide patients with end of life care that was compassionate and respected patients' needs and wishes. Families were referred to other services for support with bereavement.

Are services responsive to people's needs?

Good

The practice is rated good for responsive. The practice was accessible to patients with limited mobility, or whose first language was not English. The practice had systems in place that ensured patients with urgent needs were seen with minimal delay. There were a number of ways in which a patient could make an appointment at the practice, including online, by telephone or in person. Home visits were available for patients who were not able to attend the practice and telephone consultations were also offered where appropriate.

Summary of findings

The practice had a patient participation group (PPG) to gather patient opinion regarding the service offered. The PPG is a way in which patients and GP practices can work together to improve the quality of the service.

Are services well-led?

Good

The service is rated good for well led. The practice achieved higher Quality Outcomes Framework (QOF) results than the local average. 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 e.g. diabetes and implementing preventative measures. The results are published annually.

There was evidence of improvements made as a result of feedback from patients. Patients' views on the service were listened to and were used to improve services. The practice had a patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice.

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

All patients over 75 years of age had an allocated named GP to ensure they received co-ordinated care. There were arrangements to review patients in their own home if they were unable to attend the practice. Telephone consultations were available so patients could call and speak with a GP if they were unable to attend the practice. Care plans were in place to monitor and review their health needs. The practice worked with the palliative care team to provide support to patients receiving end of life care. Older patients who moved in care home accommodation were able to retain their GP if they wished. We received good feedback from mangers of local care home regarding the service offered by the practice.

People with long term conditions

Good

Patients with long term conditions were reviewed by the GPs and the nurses to assess and monitor their health condition so that any changes could be made to manage their condition better. Patients who were on long term medication as a result of their condition received regular reviews to assess their progress and ensure their medications remained relevant to their health needs. The practice nurses visited hard to reach patients for reviews. For example, house bound patients unable to visit the practice could have a home visit for reviews for their long term conditions. The practice achievement for QOF was better than the local average. 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 e.g. diabetes and implementing preventative measures. The results are published annually.

Families, children and young people

Good

Full maternity services are provided in conjunction with local hospitals and community midwives. Antenatal clinics were held by the local midwives on a weekly basis. The practice had a clinic for child health surveillance and worked with the health visiting team. The childhood vaccination programme was undertaken by the practice nurse. The most recent data available to us showed immunisation rates were mostly in line with the average for the CCG area. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice had extended opening hours on Monday evenings to accommodate the needs of working age patients. Patients were able to book non-urgent appointments and order repeat prescriptions around their working day by telephone or on line. The practice carried out NHS health checks for patients between the ages of 40 and 74. Opportunistic health checks and advice was offered such as blood pressure checks and advice on smoking cessation. Holiday vaccination advice was available through consultation with a practice nurse.

People whose circumstances may make them vulnerable

Good

The practice had a registration policy in place which enabled people without a permanent address to register at the practice; this could be people living in vulnerable circumstances. People had access to an interpreting service if English was not their first language so that they could have a consultation with the GP in a language they understood.

The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical service contract (GMS). The practice had a register of patients with a learning disability. However, it had not taken on the enhanced service to undertake reviews of all patients with learning disability. Consequently, patients with a learning disability were not being formally reviewed. The provider told us that reviews were undertaken outside of the criteria of the Enhanced Service.

People experiencing poor mental health (including people with dementia)

Good

The practice had a register of patients who had a learning disability. However, the practice had not undertaken the enhanced service to offer an annual health check, which includes producing a health action plan. Patients with learning disabilities often have difficulty in recognising illness, communicating their needs and using health services. Regular health checks can often uncover treatable health conditions.

Patients with poor mental health were reviewed annually and healthy minds attended the practice for cognitive minds therapy (CBT) sessions three times a week. Medication reviews were done annually by individual GPs. Practice nurses visited patients in their home for reviews of their long term medical conditions for hard to

Summary of findings

reach patient groups including people experiencing poor mental health. Patients could be those registered as house bound and therefore had difficulty attending the surgery. Other hard to reach groups were patients that did not attend the surgery for regular reviews of their long term conditions despite the practice asking them to attend.

Summary of findings

What people who use the service say

We looked at results of the national GP patient survey from 2013. Findings of the survey were based in comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

There were 277 surveys sent out and 119 were sent back for analysis which resulted in a 43% completion rate. The results of the national GP survey highlighted areas where the practice was above average in comparison to other practices in the local CCG area. We saw 96% of respondents who stated that they usually get to see or speak to a GP they preferred compared to 58% for CCG average. 95% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to an 83% local average. Also, 88% of respondents described their experience of making an appointment as good compared to 74% CCG average.

Areas below average were that respondents said the last nurse and GP they saw or spoke to was good at involving them in decisions about their care. Respondents who stated that the last GP they saw or spoke to was good at listening to them was also below average.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 35 completed cards, the feedback we received was overall positive, and patients described the quality of the service and staff as 'excellent' and 'helpful'. A small number of comment cards we reviewed stated that patients found it difficult to get an appointment at times.

On the day of the inspection we spoke with six patients. We also received similar feedback from these patients. Most of the patients we spoke with were positive about their experience but commented that it was difficult at times to get through to the reception staff on the telephone.

Areas for improvement

Action the service MUST take to improve

- Arrangements must be in place to ensure that emergency medicines are available and in date.

Action the service SHOULD take to improve

- The practice should ensure suitable arrangements are in place for obtaining, and acting in accordance with, the consent of people who use the service in relation to the care and treatment provided for them.
- Develop a protocol to record actions taken in response to medical alerts.
- Ensure staff are aware of the business continuity plan.
- Ensure prescription pads are always stored securely according to NHS Protect August 2013 Guidance.

Tettenhall Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

Background to Tettenhall Medical Practice

Tettenhall Medical Practice is a registered provider of primary medical services with the Care Quality Commission (CQC) and has one registered location (practice).This is Lower Green Health Centre, Lower Street, Tettenhall Wolverhampton WV6 9LL. The practice also has a branch surgery which is Wood Road Health Centre, Wood Road, Tettenhall, Wolverhampton, WV6 8NF. This inspection focused on the main surgery, Lower Green Health centre. However, the data we reviewed before the inspection visit represented both surgeries.

The registered patient list size is approximately 11700 patients. The practice is open Monday to Friday 8:00am to 6:30pm. The consulting hours were from 8:30am to 10:30am and 3:30pm to 5:30pm. The practice provided extended hours on a Monday from 5:30pm to 8:00pm.

There were five permanent GPs (four male and one female) who were all partners and they worked between both surgeries. The practice employed four nurses (all female), and one health care assistant (female). There were also 16 administrative staff which included secretaries and reception staff and a practice manager. Some of the administration staff (reception staff) and nurses worked at both sites.

The practice had a General Medical Service contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as for example, chronic disease management and end of life care. The practice also provided some enhanced services such as minor surgery. An enhanced service is a service that is provided above the standard GMS contract.

The practice had a slightly above average patient population who were aged 65 years and over and a slightly lower than average patient population aged 0 to 39 years in comparison to the practice average across England.

The practice had opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service.

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. This provider had not been inspected before and that was why we included them.

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the service. We also asked other organisations and health care professionals to share what they knew about the practice. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 35 completed cards where patients shared their views and experiences of the service. We carried out an announced inspection on 1 December 2014. During our inspection we spoke with a range of staff including the practice manager, clinical and non-clinical staff. We spoke with patients who used the practice. We observed the way the service was delivered but did not observe any aspects of direct patient care or treatment.

Requires improvement

Are services safe?

Our findings

Safe track record

Patients spoken with did not report any safety concerns to us and we were not aware of any major safety incidents that had occurred at the practice.

There was a procedure for recording incidents and significant events. Significant events were recorded, analysed and discussed at staff meetings with an aim to take account of any lessons to be learned. We saw that three significant events were recorded and discussed at a recent practice meeting.

We saw that the practice responded to complaints appropriately. There was a complaints register which was reviewed periodically and enabled themes and trends to be identified and acted on.

Patient safety alerts were issued when potentially harmful situations were identified and needed to be acted on. However, we did not see any clinical review of alerts evidencing that alerts had been actioned.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events were recorded, analysed and discussed at staff meetings with the aim to take account of any lessons to be learned. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. For example, we saw an incident record regarding a very poorly child who was presented at surgery. The patient was removed by ambulance 30 minutes after arrival and had emergency medical care in the mean-time. The absence of paediatric masks for administering oxygen was of concern but did not affect the outcome in this case. However, the practice took action to stock paediatric masks and the nurses were made responsible for checking stock of masks.

Reliable safety systems and processes including safeguarding

Safeguarding information was readily available for staff and all GPs had attended appropriate training for safeguarding. Records looked at showed that some staff had not attended safeguarding training and were booked to attend in January 2015.

There was a practice lead GP for safeguarding children and they had received the appropriate level of training for their role. There was no named safeguarding lead for vulnerable adults. GPs were responsible for the management of their own list of patients. We were told that practice meetings were held every Tuesday and they were used to discuss any patient concerns. There were no minutes available to confirm that any specific safeguarding concerns were shared and discussed with the wider clinical team. We saw minutes of the latest meeting that was available in reception for staff especially those staff that were unable to attend the meeting.

There were arrangements in place to share information of concern such as regular multi-disciplinary meetings with health care professionals. A staff member we spoke with gave us an example of when they had telephoned a community psychiatric nurse (CPN) for more advice due to concerns with a patient. They then spoke to the GP and raised an alert as advised.

We saw evidence that there was a system to highlight vulnerable patients on the patient's electronic records so that staff were aware of any safety concerns when they attended appointments.

We saw that a chaperone policy was in place and we were told that chaperone duties were usually undertaken by nursing staff or a member of the management team. We were told that, at times, administrative staff had undertaken the role of a chaperone. We saw that most staff had undergone DBS checks including some administrative staff. The practice manager told us the remaining administrative staff were next due to undergo DBS checks.

Chaperones were available during examinations if patients wanted one. We saw chaperone notices were displayed in the patient waiting area and in consultation rooms. Most patients we spoke with were aware that they could have a chaperone if needed.

Medicines management

There were systems in place to ensure emergency medicine and equipment stored at the surgery were safe and effective to use in the event of a medical emergency. However, the systems were not robust and we found that some emergency medicines were out of date in the GP bags.

Requires improvement

Are services safe?

We checked two doctor's emergency medicine bags. We found that although there was a checklist for checking expiry dates some drugs were out of date. The nurses were responsible for checking expiry dates of medicines kept in the surgery and the GPs were responsible for checking their own bags. The GPs made home visits to patients that could not attend the surgery as well as attending to patients who were residents of care homes. In the event of an emergency during a home visit the GPs would not be able to respond with appropriate medication. The practice must improve the way they manage medicines.

There were two dedicated fridges where vaccines were stored with a nurse responsible for ensuring regular checks were undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature range and was therefore safe to use. We saw that one of the fridges was not locked and the rooms they were located in were not locked when staff were away. Staff told us that they would now ensure rooms were now always locked.

We found that there we no system in place to for issuing prescription pads to GPs and blank prescriptions were not always stored appropriately to ensure they were only accessible to appropriate staff.

A system was in place for repeat and acute prescribing so that patients were reviewed appropriately and any repeat medications were relevant to their health needs. Acute prescriptions are medicines that have been issued by the GP but not added to the repeat prescription records.

Cleanliness and infection control

On the day of our inspection we observed that the practice was visibly clean and tidy. The practice had an infection prevention and control policy (IPC) with a responsible named lead. This was available in the shared electronic computer drive which was accessible to all. This enabled staff to plan and implement control of infection measures and to comply with relevant legislation.

There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment (PPE) such as plastic gloves. Colour coded cleaning equipment was available and disposable privacy curtains were in use and clearly dated.

We saw that a recent infection control audit had been carried out and actions identified were completed.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A contract was in place to ensure the safe disposal of clinical waste.

A legionella risk assessment had been completed to ensure that any risks to patients from potential contaminated water was identified and acted on. Legionella is a bacterium that can grow in contaminated water and can be fatal.

Equipment

The practice had emergency medical equipment available such as an automated external defibrillator (AED) and medical oxygen. The AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. However, they were not regularly checked to ensure they were in working condition. This did not provide assurance that patients were protected from the use of unsafe equipment in a medical emergency. The practice nurse we spoke with told us that they will now be implementing checks.

We saw all equipment had been tested and that the provider had contracts in place for annual portable appliance testing (PAT). Annual testing of fire protection equipment such as fire extinguishers was also in place. There were arrangements in place for routine servicing and calibration, where needed, of equipment such as weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff, including pre-employment checks. We looked at the personnel files for four members of staff including a nurse, a GP and a medical receptionist. Records we looked at showed that appropriate recruitment checks had been undertaken prior to employment. For example, references and criminal records checks via the Disclosure and Barring Service (DBS) were in place.

We were told that at times reception staff carried out chaperoning duties when other clinical staff were not available. However, some of these staff members had not

had not undergone a DBS check and did not have appropriate risk assessments in place. The practice manager told us that they had made a decision to DBS check all their administration staff. Most staff had undergone BDS checks and the remaining administration staff were due to undergo DBS checks.

The practice had a policy for checking qualification of clinicians. This policy was intended primarily for the recruitment of health professionals who required registration with an appropriate body in order to practice. We saw evidence that clinical staff were registered with their governing bodies. For example, all nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register. We saw evidence that the practice nurse had an up to date registration with the NMC.

There were clear arrangements for planning and monitoring the number of staff and mix of staff needed to meet the needs of patients. We saw evidence of staff scheduling taking into account staff on holiday and busy periods. We were told that by the practice manager that they usually planned schedules a month in advance. This allowed them to better plan staff skill mix to meet patient's needs.

Monitoring safety and responding to risk

Records showed that essential risk assessments had been completed, where risks were highlighted, measures had been put in place to minimise the risks. Various risk assessments had been reviewed recently, including fire safety and the control of substances hazardous to health (COSHH).

The practice had a fire safety policy and procedures in place. We saw that a fire evacuation flow chart was in place and we saw records that a fire drill was carried out on 8 October 2014. We saw that learning was identified as a result of the fire drill and learning points were actioned.

There were arrangements to deal with foreseeable emergencies. We saw that the staff at the practice had received training in medical emergencies such as cardiopulmonary resuscitation (CPR). The practice had an AED and medical oxygen was available. All of the staff we asked knew the location of the emergency medicines and equipment. However, we saw that there were no regular checks in place to ensure that the medical oxygen and the AED were in working order. The practice nurse told us that this would now be done along with checks that were already in place for emergency medication.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan. This covered a range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. However, not all staff we spoke with were aware of the plan and would not know the actions to take during an emergency or major event.

The practice had an emergency call icon on all computer screens via EMIS web. In the event of a medical/fire emergency this icon would be activated. This alerted staff in other parts of the building to the emergency and requested them to respond to it. Reception staff demonstrated to us how this worked.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians we interviewed were able to describe and demonstrate how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE) and doctors.net modules. NICE provides national guidance and advice to improve health and social care. Doctors.net. provides online continuing medical education (CME) modules designed and developed by doctors, for doctors.

However, we were told that there were five GP partners at the practice with one of the partners being a senior partner responsible for making most decisions. Each GP managed their own list of patients and there was no overall mechanism in place to ensure that all the GPs were adhering to best practice guidance. For example, some GPs were aware of the importance of seeking written consent for minor surgery while others did not.

Vulnerable patients with long term conditions were assessed so that help, support and advice could be personalised. Patients over 75 years old had a named accountable GP and were involved in developing their care plan to enable increased monitoring and follow up care.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to hospital. GP practices can opt to provide additional services known as enhanced services that are not part of the normal GP contract. By providing these services, GPs can help to reduce the impact on secondary care and expand the range of services to meet local need and improve convenience and choice for patients. The focus of this enhanced service was to optimise coordinated care for the most vulnerable patients to best manage them at home. This allowed the practice to proactively assess the needs of their at risk patients with the aim of developing better management strategies. The care plans were reviewed every two weeks to ensure changes to patients needs were incorporated.

There were no dedicated chronic disease clinics available with the nurse and GP for conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, IHD (Ischemic heart disease) or stroke. We were told by the partners that the practice strategy was opportunistic assessment and to target all hard to reach groups by getting the nurses to visit patients in their own homes.

Patients who were receiving end of life care had a named GP and there were arrangements to share information with out of hours services for when the practice was closed. Meetings were held with the palliative care teams to ensure coordinated care was provided.

The practice referred patients appropriately to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enabled patients to choose which hospital they would prefer to be seen.

The practice had a list of patients with a learning disability. However, there was no formal review of these patients as the practice was not taking part in an enhanced scheme for disability patients. Patients with learning disabilities often have difficulty in recognising illness, communicating their needs and using health services. Regular health checks for patients with learning disabilities can uncover treatable health conditions. After the inspection the provider informed us that reviews were carried out on these patients informally outside of the strict criteria of the Enhanced Service.

Management, monitoring and improving outcomes for people

One of the GP partners reviewed avoidable attendances at the local accident and emergency (A&E) department. Avoidable attendances are those where, if the patient had been seen in the GP practice instead, they could have been assessed and managed by their GP. We saw that the practice had a lower A&E attendance than the CCG average even though the practice had a slightly higher than national average older patient population. This suggested that patients were managed well at the practice.

There were arrangements in place to ensure women received cervical smear tests by staff that were appropriately trained. Samples were sent to a local NHS hospital to be analysed and reported in line with national guidance and recall systems. We saw the nurse kept a record of smears and where an inadequate smear was notified by the hospital appropriate action was taken.

Good

Are services effective?

(for example, treatment is effective)

The practice had a system in place for completing clinical audit cycles. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice e.g. clinical guidance; to measure whether agreed standards are being achieved, and to make recommendations and take action where standards are not being met. Examples of clinical audits included an asthma audit and osteoporosis audit. The audits were on-going and had not been completed and therefore there were no actions for follow up.

The GPs managed their own list of patients which meant that patients received continuity of care. However, there were no mechanisms in place to share learning and to monitor if clinicians adhered to best practice guidance. Consequently, care delivered by them was inconsistent and did not always follow guidance. For example, there was an inconsistency in the way consent was sought for minor surgery.

Effective staffing

Records demonstrated that most of the staff had completed essential training to support safe, effective practice such as basic life support and safeguarding. Some staff required refresher training for safeguarding and were booked to attend in January 2015.

New staff received induction training and the practice had systems in place for annual appraisals for all staff and staff that we spoke with confirmed this.

Two of the GPs who worked at the practice had undergone revalidation and others were due external revalidation of their practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine.

Working with colleagues and other services

Clinical staff attended regular meetings with relevant health care professionals and agencies to discuss and review patients who had complex needs, were in vulnerable circumstances or were receiving end of life care. This ensured that their wishes were respected, and they received appropriate support and treatment. For example, we saw evidence that regular meeting were held with the palliative care team. The practice also worked with healthy minds who provide mental health and specialist learning disabilities services to people of all ages. Healthy Minds is an NHS primary care psychological therapies service that works closely with GPs. It offers advice, information and brief psychological talking therapies for people aged 16 and over, who are often feeling anxious, low in mood or depressed. District nurses were also able to contact relevant GPs directly about a patient which allowed quicker sharing of information.

The practice provided general medical services to patients living in residential care homes. We spoke with three care home managers and discussed the arrangements for reviewing older patients. They were positive about the service received from the practice. They told us that the GPs were very professional and thorough and would do home visits if necessary. One of the care home managers told us that if there was a change in the repeat medication of a resident, the GPs would telephone them and also telephone the pharmacy and inform them. Another care home manger added that 'everyone knew everyone' and this helped with the management of patients.

We saw evidence that a robust system was in place to review clinical test results, relevant letters, and referrals and follow ups for patients. Blood results received were actioned by the GP on the same day and actions were managed by a relevant designated staff member. When abnormal blood test results were received the GPs used the electronic task system on the computer for the administration team. The administration team then called the patient to come into the practice to speak with their GP. The administration team told us that they did not clear the task until the patient had made an appointment to see the GP.

There was a national recall system in place for cytology screening which was carried out by the practice nurse. This ensured women received this important health check including receiving their test results in a timely manner and findings were audited to ensure good practice was maintained.

The practice had opted out of providing out of hours services (OOH). This had been contracted by the CCG to an external service provider. The practice faxed appropriate information of patients that were on end of life (EOL) care so that the OOH service would be aware of any management needs while the practice was closed. The

Good

Are services effective?

(for example, treatment is effective)

practice also received an electronic summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the GPs at the practice.

Information sharing

We found that the practice worked with other service providers sharing information to meet the needs of patients and manage complex cases. Multidisciplinary working was evidenced, for example joint working arrangements were in place with the palliative care team, meeting with the practice quarterly. Monthly admissions avoidance meetings were held with healthy minds.

We saw evidence that GPs contacted services appropriately when patients moved between teams and services. For example, a care home manager told us that when there were changes to the repeat prescription of a resident, the GPs would call the appropriate pharmacy as well as the care home to inform them of the changes.

The practice used the Choose and Book system to make referrals. The Choose and Book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital. A care home manager we spoke with told us that two cancer patients they were caring for were referred by the practice appropriately.

Consent to care and treatment

The GPs managed their own list of patients and each GP was responsible for their own learning. This resulted in inconsistencies in the way clinicians applied their knowledge. For example, we identified some gaps in knowledge and training for Mental Capacity Act. Some GPs were aware of the Mental Capacity Act while other GPs were not aware of the Mental Capacity Act. The Mental Capacity Act is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.

Doctors in the surgery undertook minor surgical procedures in line with their registration. It should be noted that if a practice is commissioned to undertake enhanced services such as minor surgery their commissioner and their accrediting body will expect an audit of all patients receiving the service. Most GPs we spoke with told us that they did not seek written consent before performing minor surgery. Only one GP we spoke with told us that they sought written consent for minor surgery and they showed us the form they used. This did not provide consistency in the approach to care treatment. Also, it did not provide assurance that patients had given informed consent to their treatment or that risk, benefits and complications of the procedure had been discussed.

Health promotion and prevention

The practice carried out NHS health checks for new patients and patients aged between 40 - 74 years old. The health checks were carried out by the practice nurse and the health care assistant (HCA). If there were any complex cases it would be reviewed by a GP for more advice and guidance.

Patients were encouraged to self-manage and monitor some conditions. For example, patients with abnormal blood pressure were encouraged to monitor their condition at home and seek advice when appropriate.

The practice leaflet was available in the reception area and to download online from the practice website. The information leaflet listed the types of health services available at the practice. The practice website also listed a more comprehensive list of services offered to patients. They included dietary advice, children's immunisations, maternity care (midwives held weekly antenatal clinics) and stop smoking advice amongst other services. Although these services were offered we found that there were very few specialist clinics held. For example, managing long term conditions such as diabetes. The practice approach was for the nurse to visit patients at home as well as opportunistic review of patients. However, the practice had achieved good QOF scores comparable to other practices in the locality which suggested that they adequately managed patients with long term conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested a private discussion. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and those conversations that took place in these rooms could not be easily overheard.

On the day of the inspection we spoke with six patients. In addition we looked at 35 patient comment cards and feedback from the 2014 national practice patient survey, We also spoke with managers of three care homes to get their feedback. Most of the patients we spoke with were very satisfied with the care and treatment they had received. They said staff were friendly and caring. They felt involved during consultation and said any results of tests were explained to them in a way they understood. Care home managers told us that the service they received was professional and met the needs of the residents in the care homes.

The practice had a patient population of 11700 and the national GP patient survey showed that the practice performed better than the local CCG average. For example, 95% of respondents in the survey were able to get an appointment to see or speak to someone the last time they tried compared to the local CCG average of 83%. The practice also performed better than average in providing good continuity of care. For example, 96% of respondents stated that they usually get to see or speak to that GP they preferred. This was also because each GP managed their own list of patients and appointments were made with the same GPs. However, we spoke with one patient who told us that they had been assigned a GP when they had recently registered and were not allowed to change the GP event though they preferred another GP. During our inspection visit this patient was allowed to see another GP and staff told us that patients were able to register with any GP they preferred.

Care planning and involvement in decisions about care and treatment

We noted that the GP patient survey revealed that patients felt that the last clinician they saw was not good at listening and involving them in their care. We looked at the appointment system and saw that 20 appointments were offered by each GP per session. Although this provided good access to appointments we also saw there were three to four, five minute appointments for minor consultations per session. We discussed whether this may explain why patients stated that the clinicians were not good at listening and involving them in decisions about their care with some of the partners. However, the partners did not feel that this was the case.

The practice also had access to an interpreting service for patients whose first language was not English. There was a hearing loop induction system in place to help people with hearing problems.

The practice was working towards registering carers and we saw a notice in the reception area encouraging them to inform the practice. We saw evidence that carers were involved when the practice developed care plans for its patients with complex needs, elderly and vulnerable patients.

We saw inconsistencies between clinicians on the training, knowledge and application of the mental capacity act (2005). However, we also saw an example of best interest decision made in accordance with the act which was recorded in patient notes.

The practice had a consent template for minor surgery however, our conversation with the clinicians revealed that they were not consistently used.

Patient/carer support to cope emotionally with care and treatment

Although we found that there was no formal setup to support people during bereavement. The practice referred patients to Cruse bereavement care. Cruse bereavement care provides support to people after the death of someone close. It offers information, publications, and support for children as well as delivering face to face and group support by trained bereavement support volunteers. Other support services that patients could be referred to were healthy minds, hospice support for families of palliative care patients as well as counselling clinics.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. There were nurse led services such as the travel advice and inoculations, cervical smear tests as well as disease management services which aimed to review patients with common illness and ailments. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated.

The practice had implemented the gold standards framework (GSF) for end of life care. They had a palliative care register and regular multidisciplinary meetings were held to discuss patient and their families care and support needs.

Patients who had appointments could use an electronic touch screen monitor in the waiting room to confirm their arrival, or could speak with the staff at the reception desk. The touch screen is designed to let patients book in for their appointments automatically.

We saw that the practice had advertised for more members for the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The practice manager told us that there was an active PPG but the numbers had recently reduced. We saw that the PPG had carried out a survey in May 2014 and an action plan was developed to implement some of the findings. We saw that the survey revealed that most patients were not aware of the PPG and a decision was made in November at the PPG annual general meeting to better promote the group. We saw there was a PPG notice board in the entrance area of the practice so all entering the practice would notice. The board advertised the PPG and encouraged patents to join the group.

Tackling inequity and promoting equality

Patients who were vulnerable due to their health or social circumstances were offered health checks. The practice also had access to an interpreting service for patients whose first language was not English and an induction loop was available for patients who had difficulty with their hearing.

The main practice site was a purpose built building which met the needs of patients with disabilities. Access into the premises was via a ramp and automatic doors. There were disabled toilet facilities available. The practice was situated on the ground floor of the building with wide corridors and large waiting area which could accommodate patients with wheelchairs and pushchairs and allowed for easy access to the consulting rooms. The practice manager told us that a Disability Discrimination Act (DDA) audit was completed by the previous Primary Care Trust (PCT, now replaced by CCG) to show compliance with the Disability Discrimination Act 1995 .This act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. However, there was no copy of the audit available at the practice.

Access to the service

The practice was designed to be accessible for wheelchairs and pushchairs. There were disabled toilet facilities and a loop induction system for patients with hearing impairment.

The practice had extended their surgery hours once weekly from 5:30pm to 8:00pm to facilitate working and other patient groups who could not attend during normal surgery hours.

Home visits and urgent on the day appointments were available each week day. We spoke with three care home managers who told us that they had no problems with getting a GP to visit their patients.

All surgery opening times were detailed in the practice leaflet which was available in the patient waiting room and on the practice's website. The practice website also outlined how patients could book appointments and organise repeat prescriptions online.

The practice had a registration policy in place which enabled people without a permanent address to register at the practice; this often could be people living in vulnerable circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We spoke with six patients who told us that access to the surgery was not an issue. Patents were seen promptly and did not have to wait too long after their appointment time to be seen. We saw that this was reflected in the national GP survey where the practice had performed better than the CCG average.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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. We saw that there had been five complaints made in the last 12 months and all had been responded to. There was a complaints register which was reviewed periodically and enabled themes and trends to be identified and acted on. Sharing of lessons learnt and discussions with staff were included in staff meetings.

We saw that there was a poster on display in the patient waiting area informing patients on how they could make a complaint. There was a complaints leaflet available and a policy displayed also included contact details of organisations that patients could escalate complaints to.

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

There were five GP partners one of whom was a senior partner. They told us that they wanted to retire soon and it was clear that some discussion around succession planning had taken place. However, this was not formalised.

The practice manager and staff who we spoke with demonstrated the values of the practice and a commitment to improving the quality of the service for patients. For example, the practice aimed to provide a personal list system with flexibility of appointments where necessary to ensure patient's received continued care from a GP who knows them well. We saw that each GP had a personal list of patients. However, this also meant that at times approach to care delivery was not consistent.

Governance arrangements

There was a clear administrative leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and there were systems in place to monitor and improve quality and identify risk. All the policies were available to staff via the desktop on any computer within the practice. Administrative staff were aware of their roles and responsibilities**.** However, each GP partner managed their individual patient list and there were no overall clinical strategy. For example, we saw some inconsistencies in the training, knowledge and implementation of the Mental Capacity Act (2005). This was because each GP mostly undertook self-learning and implemented their own learning individually. A GP we spoke with told us that there were lots of complicated rules to follow as a result of personalised patient lists. The practice nurses we spoke with told us that if they needed further help and advice regarding a patient they needed to approach the GP that the patient was registered with. This did not always ensure swift management of patients' needs and we discussed our findings with some of the staff including partners during the inspection. The GPs told us that the individual clinician managing the patient would be better aware of the needs of the patients.

Leadership, openness and transparency

The practice manager and staff who we spoke with demonstrated the values of the practice and a commitment to improving the quality of the service for patients.

The practice aspired to deliver good continuity of care and the way the patient lists were managed allowed the practice to deliver this. This was confirmed by some of the patients we spoke with, the comments cards we received and national GP survey results. However, this also led to inconsistencies in the way care was delivered at times. For example, in the way formal consent was sought. The GPs we spoke with told us that the practice meetings allowed them to discuss some issues such as incidents.

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

We saw that the practice had a PPG to promote and support patient views and participation in the development of services provided by the practice. We saw that the PPG had carried out a survey in May 2014 and where improvements were required these were acted upon. For example, the PPG fed back that conversations at the reception desk could be overheard by other patient's queueing at the reception desk. The practice responded by informing patients to keep their distance when queuing at the reception desk and we saw that there were notices displayed advising this. The practice manager told us that they did not own the building and that they had spoken with NHS business services authority to have barriers installed.

The practice also acted on feedback provided by patients directly. For example, we were told that many patients had commented that they were unable to get through on the telephone at 8:00am when the surgery opened to make an appointment. The practice responded by informing patients to call the practice at 8:00am if it was urgent and to call after 9:00am if it was for a routine appointment. This was done through displaying a note in the reception area and also informing patients on the practice website.

The practice gathered feedback from the staff generally through appraisals, meetings and informal discussions. A staff member we spoke with told us that they didn't always feel that they were listened to particularly when it involved changes to how clinicians worked. Other staff members we spoke with were positive about the support they had received.

Are services well-led?

Good

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

Management lead through learning and improvement

Learning from complaints and significant events were shared with staff to help learning and improvements.

The practice had responded to feedback on service delivery from the PPG as well as other patients through surveys and complaints. We saw that changes had been made to improve service as a result of feedback.

We saw that the practice had a system in place for completing clinical audit cycles. Examples of clinical audits included asthma audit and osteoporosis audit. The cycle had not been competed yet and therefore it was difficult to determine learning and the resultant improvements.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that people who used the service were not protected against the risks associated with the unsafe use and management of medicines by ensuring appropriate arrangements for the recording, handling and safe keeping. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.