Gloucester Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Gloucester Road Medical Centre on 12 March 2015. Overall the practice is rated as GOOD.

We found the practice to be good for providing responsive, effective, safe, caring, well led services for older adults, families and children, patients with long term conditions, vulnerable patients, patients with mental health issues and patients who worked.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand.
- Overall patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice used a comprehensive, bespoke practice, management and information system for the recording, and monitoring of all the practice quality and monitoring processes.

Summary of findings

However there were areas of practice where the provider needs to make improvements:

The provider SHOULD:

- Ensure all staff undertake infection control updates in line with the practice policy.
- Ensure all sharps disposal boxes are correctly labelled and changed in line with national guidance.
- Ensure a record of medicines stocked in the practice is kept to demonstrate how they are being used.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Overall, patients said they were able to get an urgent consultation with a practice GP on the day of need. There were urgent appointments available and a telephone call back service. Appointments could be booked up to four weeks in advance and patients were usually able to see a named GP within two weeks. The practice was open every Saturday morning for pre booked appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice was aware of the challenges to the practice and were proactive in their management. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended team meetings.

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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive personalised care to meet the needs of the older people in its population and offered home visits and support to three local care homes. The practice delivered a range of enhanced services, for example, end of life care and avoiding unplanned admissions to hospital.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care based on a person centred care plan.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We were given examples to demonstrate staff understood issues regarding consent and confidentiality when supporting young adults and children with mental capacity. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered free, confidential contraceptive and sexual health advice to young people.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).The practice provided screening for common medical conditions and telephone health

Summary of findings

reviews. They offered a flexible appointment system including earlier morning, later evening and Saturday morning appointments which could be booked online, telephone or a visit to the practice. Patients were able access to access health information via the practice website.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and had carried out annual health checks for these patients. The practice told us the number of patients attending for cervical smears had increased since the introduction of 'easy read' information.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. They told us they had recognised and referred women to a specialist clinic when female genital mutilation was suspected.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 70% of people experiencing poor mental health had a care plan to support their care and treatment. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had information for patients experiencing poor mental health about how to access various support groups and voluntary organisations including the Recovery Orientated Alcohol and Drugs Service. Staff had received training on how to support patients with dementia. They utilised a mental capacity assessment tool developed by the practice when they had concerns about changes in a patient's capacity to give consent and understand information.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with seven patients attending the practice. We looked at five patient comment cards, the practice survey (2013) with 335 respondents, the GP National Patient Survey 2013/2014 and three comments (2014) on the NHS Choices website.

Overall, patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients were satisfied with the care and treatment received. Generally staff were described as professional, helpful and thorough. This was supported by feedback from the GP National Patient Survey 2013/2014 which indicated 84% of the practice respondents said the last GP they saw treated them with care and concern. 91% of respondents described their experience of the practice as fairly good or very good. Patients we spoke with felt their privacy and dignity were respected. The practice was rated among the best, with 91% of patients saying they would recommend the practice to family and friends. (NHS Choices 2014)

Patients' feedback told us patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. Feedback from the GP National Patient Survey 2013/2014 indicated 83% of patients said the last GP they saw was good at involving them in decisions and 91% said the last nurse they saw was good at explaining tests and treatments.

95% of patients in the GP National Patient Survey (2013/2014) said their last appointment was convenient for them. Generally this comment was reflected in other patient feedback we received. All of the patient feedback told us patients were able to see or speak to a GP if their appointment was urgent on the day of need. However, patients requesting to see the GP of their choice had a longer wait of up to two weeks. Some patients indicated it was difficult to get through to the practice by telephone to make an urgent appointment particularly when the practice first opened in the mornings. The practice response was that more on the day appointments were being released to meet patient demand. In addition patients were advised to use all the other alternative means of booking appointments, i.e. mobile phone app and practice website. The triage system meant patients were able to speak to a GP to assess the support required.

Patients told us they appreciated they were able to book appointments up to four weeks in advance which helped with planning work commitments.

Patients we spoke with were not aware of the complaint process even though there was information available in the practice. They expressed confidence in the practice to address concerns when they were raised.

Patients told us they were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider SHOULD:

- Ensure all staff undertake infection control updates in line with the practice policy.
- Ensure all sharps disposal boxes are correctly labelled and changed in line with national guidance.
- Ensure a record of medicines stocked in the practice is kept to demonstrate how they are being used.

Gloucester Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and an observer from the Department of Health.

Background to Gloucester Road Medical Centre

As part of the inspection we visited Gloucester Road Medical Practice at Tramway House, 1A Church Road, Bristol, BS7 8SA.

Gloucester Road Medical Centre provides primary care services to patients resident in the city of Bristol. The practice is purpose built with most patient services located on the ground floor of the building with a patient lift to access the first floor. The practice has an expanding patient population of 13,271 of which the highest proportion are of working age including a percentage of students. The practice trains GP's, medical students and student nurses.

The practice has six GP partners. They employ three GPs, seven nursing staff, one phlebotomist, a business partner, and reception/administration staff. Most staff work part-time.

The practice is open six days of the week. Monday to Thursday it is open 8.15am – 7.00pm and Friday 8.15-6.30pm. The practice is open on Saturday mornings from 8.15am -11am for pre-booked appointments.

The practice has opted out of the Out of Hours primary care provision. This is provided by another provider BRISDOC.

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

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 patients' needs?
- Is it well-led?

Detailed findings

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

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

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the Bristol Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 12 March 2015. During the inspection we spoke with four GPs, business partner, four nursing staff, administration and reception staff. We spoke with seven patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw for example, drug prescribing errors were discussed at significant event reviews. The practice worked with the practice support pharmacist (a pharmacist employed to provide guidance and advice to GP practices) to act on relevant, urgent medicines alerts.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. There was a dedicated meeting held quarterly to review actions from past significant events and complaints. In addition significant events were reviewed on an ad hoc basis at the weekly clinical meeting agenda. There was evidence that the practice had learned from these reviews. The findings were shared with relevant staff usually via team leaders. We saw from meeting records there were plans to involve administrative staff more frequently in practice meetings where safety issues were discussed. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. Nursing staff told us they had recognised and referred women to a specialist clinic when female genital mutilation was suspected.

The practice had dedicated GP leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients and their families on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There were notices in all patient areas advising patients about requesting a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We noted a record of medicines stocked was not kept by the practice to demonstrate how they were being used.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Good

Are services safe?

We were told there was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. An electronic record was made of who collected the prescription to provide an audit trail in the event of prescriptions reported as missing. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The repeat prescribing procedure protected patients from risk. There were systems in place to identify when patients required a medicines or health review before further prescriptions were issued. Drug interactions and drug alerts were clearly identified on the practice electronic system. Newly registered patients taking regular medicines were seen by a GP for a health check.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Infection control audits were completed every four months. We saw evidence there had been three infection control audits completed in 2014. Any improvements identified for action were completed on time. The practice policy for infection control updates for nurses and GPs was annually. We noted all but three staff (GPs) had completed the training in line with the practice policy.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The needle stick injury policy was due to be updated as arrangements for occupational health support was under review. Staff knew the first aid procedure to follow in the event of a needle stick injury however, not all staff were clear about the procedure for obtaining further medical advice.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Sharps disposal boxes were stored safely. However, we noted the information labels on two sharps disposal boxes indicated they were not changed every three months in line with national guidance (NICE 2012).

Equipment

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

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Staff explained the interview process and we saw completed interview schedules to demonstrate the process for selecting candidates.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was dedicated member of staff to manage the staff rota system for GPs and administrative staff. The processes in place to ensure there were enough staff included accurate recording and monitoring of staff leave and guidance of when to book a locum GP based on the number of anticipated patient

appointments available each day. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We were shown records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and all staff attended health and safety training.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We were told that any risks were discussed at practice meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Nurses and GP's undertook training annually and administrative staff every three years.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. A patient explained how staff had managed first aid treatment to a suspected eye injury, with timely referral to the eye hospital.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. There was a buddy system with another local practice in the event of a major emergency.

The practice had records to demonstrate there had been a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from other research reports. The GPs met weekly to discuss and present clinical issues such as updates in best practice evidence. For example, NICE guidelines on the management of patients with cardiovascular disease (heart disease). In addition the GPs met daily to discuss complex cases and share learning about the appropriate management required.

The use of guidance prompted clinical audit and reviews of clinical guidelines. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the use of care pathways and care plans for patients with long term conditions such as heart and respiratory disease. Nursing staff were able to explain how they decided on the most appropriate wound care treatment by reference to NICE guidance, knowledge of colleagues and 'expert patient' experience when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Patients with long term conditions were reviewed and monitored by the nurses. If patients had multiple co-morbidities (a number of medical conditions) such as diabetes and respiratory disease they could have their needs addressed in one session rather than attending different clinics.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We looked at data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used a risk stratification tool to identify 2% of the most vulnerable patients on the practice list. We saw that all these patients had a personalised care plan to assist in their support and treatment to avoid admission to hospital.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us nine audits had been completed in 2014. Some of these were data collection audits for example, the number of cancer diagnoses or children presenting with minor illness.

The practice had completed two clinical audits where changes to treatment or care were made where needed which had then been repeated to ensure outcomes for patients had improved. For example, following a review of referrals to ear nose and throat (ENT) hospital services a clinical audit was undertaken. The aim of the audit was to evaluate whether patients were appropriately managed in line with best practice guidance. Results from the first audit demonstrated that 50% of the small sample of patients meeting audit criteria could have been managed more effectively prior to hospital referral. The information was shared with GPs and GPs were provided with a clinical guideline as a source of reference. A second clinical audit six months later demonstrated that all patients referred to hospital had been managed appropriately.

We looked at another audit regarding the monitoring of patients on warfarin (a medicine used to thin blood. An essential part of monitoring patients prescribed blood thinning agents is to identify whether their blood is clotting effectively). The second audit cycle demonstrated more patients had blood results within the normal range and some patients were prescribed alternative medicines. The practice had identified blood tests were not undertaken at medicines review and length of treatment was not documented in patient record however, dates for

Good

Are services effective?

(for example, treatment is effective)

implementation of these practices were not identified. We saw there was also a range of prescribing audits undertaken as part of the Bristol Clinical Commissioning Group prescribing incentive scheme.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 74% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ and chronic obstructive pulmonary disease (lung disease). The practice was above the Clinical Commissioning Group average for 19 of the 20 medical conditions measured against the minimum standards.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that overall all staff were up to date and had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional training and qualifications in sexual and reproductive medicine and diabetes. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines, cervical smears and some extended roles such as asthma and diabetes reviews. The specialist practice nurse was a nurse prescriber and undertook minor illness sessions for conditions such as coughs, colds and urinary tract infections.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, one nurse was undertaking a diabetic diploma supported by the practice. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. The practice also offered placements for student nurses as part of their graduate nurse training programme.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for an enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) to support frail patients to avoid admission to hospital. The GPs worked with the multidisciplinary team to develop and review patient care plans to meet the changing needs of these patients. There was a process in place to follow up patients discharged from hospital. We saw that the procedure for actioning hospital communications was working well in this respect.

The monthly multidisciplinary team meetings provided an opportunity to discuss the needs of other patients with complex needs, for example those with end of life care

Good

Are services effective?

(for example, treatment is effective)

needs, or children on the 'at risk register', or long term conditions. These meetings were attended by health visitors, midwives, district nurses and palliative care nurses as appropriate.

The practice supported patients living in three nursing/care homes. A dedicated GP undertook a 'weekly ward round' in one care home to review patients care and treatment. In addition the GP offered staff training one example being to raise staff awareness around the standards for QOF achievement.

The prescribing lead GP met regularly with the prescribing support pharmacist to review practice prescribing, prescribing audits and medicine alerts.

The practice worked with a range of other agencies to support vulnerable patients and those patients experiencing poor mental health. For example, the practice worked in partnership with a local drug project worker in the assessment, monitoring and support of patients requiring help with drug misuse.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, for example, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had also signed up to the electronic Summary Care Record and was fully operational in November 2014 (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was comprehensive information for patients about this on the practice website.

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

Consent to care and treatment

We found that GPs and nurses applied the principles of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 to their practice area.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). We noted all patients on the dementia register had been reviewed in 2014.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Overall nursing staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions) and a duty of confidentiality to children and young adults. For example, the refusal to disclose patient information to a parent without first seeking the young person with capacity had consented. We found the practice consent policy provided clear guidance for staff on the legal and ethical implications of consent.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had number of ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse and GP. The practice offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had strategies to enable patients to take responsibility for their own health when they were able. There was a range of health promotion information in the practice and on the website for all patient groups. 'Easy read' information was available for patients with learning disabilities requiring a cervical smear. Patients were able to monitor their blood pressure by using the self- monitoring machine in the practice. Results were given to reception

Good

Are services effective?

(for example, treatment is effective)

and seen by a GP to evaluate the need for further follow up. Young adults had access to confidential, free sexual health and contraceptive advice whether they were patients with the practice or not. In addition free screening kits for chlamydia (a sexually transmitted disease) were available for under 25's. The practice actively offered smoking cessation clinics to patients.

The practice's performance for cervical smear uptake was 76%, (National Intelligence Cancer Network 2013) which was significantly higher than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. Performance for breast and bowel cancer screening was similar to the average for the CCG (National Cancer Intelligence Network 2013 66.6% and 58.8% respectively).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG. There was a protocol to follow up non-attenders.

Patients who did not attend for health checks, reviews or follow up appointments were contacted to arrange for another appointment if nurses or GPs were concerned about their wellbeing.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP National Patient Survey (2013/2014), a practice survey of 335 patients (2013) The evidence from all these sources showed patients were overall satisfied with how they were treated. For example, data from the GP National Patient Survey (2013/2014) indicated 89 % of respondents rated the practice as good or very good. The GP National Patient Survey identified 84% and 94% of practice respondents said the GP and nurse (respectively) was good at treating them with care and concern. 88 and 94% of respondents said the GP and nurses (respectively) were good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and spoke to seven patients. There were some mixed reviews about staff attitudes however this was balanced overall by a number of positive comments and the feedback from the practice survey and the GP national patient survey. Patients said they felt the practice offered a very good service and staff were generally compassionate, professional, supportive and caring. They said staff treated them with dignity and respect. We observed a number of examples of kind and caring interactions with patients.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

The practice switchboard was separated from reception so that telephone conversations were not easily overheard. There was a sign to inform patients of the availability of a private room for confidential conversations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the GP National Patient Survey (2013/2014) showed 83% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results compared favourably to the CCG average.

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

Staff told us that translation services were available for patients who did not have English as a first language. The patient self-check in information was offered in a range of languages and there was a quick link to translation services on the practice website.

Patient/carer support to cope emotionally with care and treatment

The nurses we spoke with demonstrated their understanding of how mental health issues impacted on their patients.

Information in the patient waiting room, and patient website directed patients to a range of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw there was written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the practice patient survey 2013. For example, improving patient access to the phone in the mornings by increasing the number of staff available to respond to calls and an extra phone line for incoming calls.

The practice had an expanding patient population of which the highest proportion were of working age. In response to this the practice offered a flexible appointment system opening early and late one day a week and a Saturday morning for patients not able to attend during normal working hours. The practice had signed up to an out of area GP registration service so patients working locally but living out with the practice catchment area could access practice services during the working week.

We were told by nurses and GPs some patients had routine health checks via telephone consultation. This was confirmed by patients we spoke with who were appreciative of the service. In addition, some patients were able to use the blood pressure self-monitoring machine in the practice which avoided the need for making an appointment with the GP or nurses unless there was cause for concern. Patients had access to some specific investigations such as spirometry, 24 hour electrocardiogram (ECG) monitoring and 24 hour blood pressure monitoring reducing the need for hospital Patients with long term conditions had regular health reviews.

The specialist practice nurse held minor illness clinics and in addition was a nurse prescriber enabling patients' timely access to support and treatment for conditions not requiring a GP.

The practice was part of a first wave pilot scheme funded by the Prime Ministers Challenge fund to explore projects that may have improved patient access to GP services. For example, 'web GP' an online health information and advice programme for patients.

Systems were in place for identifying and following-up children who were at risk. For example, the GP met regularly with health visitors to review children and their families at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. GPs offered a range of contraceptive services for patients and chlamydia (a sexually transmitted disease) screening kits for under 25's.

The practice had information for patients experiencing poor mental health about how to access various support groups and voluntary organisations including the Recovery Orientated Alcohol and Drugs Service. Staff had received training on how to support patients with dementia. They utilised a mental capacity assessment tool developed by the practice when they had concerns about changes in a patient's capacity to give consent and understand information.

Patients experiencing low mood and anxiety were referred by the practice to local psychological services for psychological interventions and support.

Tackling inequity and promoting equality

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

The practice held a register of patients with learning disabilities. The practice told us they were highest performing practice in the locality for undertaking health checks for patients with learning disability. Quality and Outcomes Framework (QOF 2013/2014) demonstrated the practice was above the Clinical Commissioning Group average.

Longer appointments for patients with learning disabilities were arranged in recognition of the time needed to involve patients in their care and treatment. Patients with learning disabilities had access to easy read copies of health promotion information such as cervical smear screening and breast examination.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patient services were situated over the ground and first floor of the building. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. We noted signage to clinical areas was black on a yellow background to assist the visually impaired. Disabled toilets had toilet ware such as toilet seats in a contrasting colour to white which would have assisted the visually impaired and some patients with dementia.

Practice staff met regularly with members of the multidisciplinary team to support those patients at end of life or with long term conditions. Nurses and GPs used their own mental capacity assessment checklist to assist with the identification of patients with diminished capacity. We found the checklist to be comprehensive and straightforward. Patients identified as lacking mental capacity could then be offered further investigations and support.

The practice provided equality and diversity training through e-learning. Training records confirmed overall staff were up to date with their training. The practice had access to online and telephone translation services for patients where English was not their first language.

Access to the service

The practice was open six days of the week. Monday to Thursday 8.15am – 7.00pm and Friday 8.15- 6.30pm. The practice was open on Saturday mornings from 8.15am -11am for pre-booked appointments. Patients were able to book appointments in person, by telephone and online.

Patient feedback indicated they were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if there need was urgent. They also said they could see another doctor if there was a wait to see the doctor of their choice. The practice told us patients were offered telephone consultations and could book appointments up to four weeks in advance. Some patients indicated it was difficult to get through to the practice by telephone to make an urgent appointment particularly when the practice first opened in the mornings. The practice had responded by increasing the number of staff available to respond to calls and an extra phone line for incoming calls. In addition patients were advised to use all the other alternative means of booking appointments, i.e. mobile phone app and practice website. The practice manager told us there were more on the day appointments (50%) released to meet patient demand. The triage system meant patients were able to speak to a GP to assess the support required.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and 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 in the practice leaflet and website.

Appointments were available outside of school hours for children and young people. Young adults had access to confidential, free sexual health and contraceptive advice whether they were patients with the practice or not.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three care homes including a 'weekly ward round' at one of the homes.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Although patients we spoke with were not aware of the process to follow if they wished to make a complaint they said they felt able to report concerns and had confidence the practice would manage them appropriately. None of the patients we spoke with on the day of the inspection had ever needed to make a complaint about the practice.

The practice reviewed complaints regularly to detect themes or trends. Sixteen complaints were reported in 2014/15. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear understanding about the strengths and challenges to the practice and the patients it supported. They gave examples of how and where improvements could be made such as improved services for carers and greater involvement of administrative staff in practice meetings. The practice statement of purpose emphasised the delivery of high quality care and the promotion of good outcomes. The practice values emphasised a professional, friendly and responsive approach dedicated to providing high quality personalised care to all its patients. Staff we spoke with were aware of the practice values and we saw examples of how these values were reflected in practice. For example, we observed staff were caring and respectful, and found them knowledgeable about their patients' specific needs to enable a high standard of care and treatment.

Governance arrangements

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a nurse with lead responsibilities for infection control and two GPs had lead responsibilities for safeguarding.

The practice had policies and procedures in place to govern activity and these were available to staff via the practice quality and management system. We looked at a range of these policies and procedures and saw staff had confirmed when they had read the policy. We looked at ten policies and procedures and identified that nine policies were up to date with the exception of the needle stick injury policy (2012)

The practice held regular practice meetings including governance issues. We looked at minutes from the meetings and found performance, quality and risks had been discussed.

Significant event and complaints records were consistently completed as a learning resource. In particular the complaints records were detailed with regards to the issue the actions taken and the learning points.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was generally performing above national standards.

The practice had completed a number of audits, for example, audits of warfarin treatment and sinusitis management and referral. Two audits had completed a full audit cycle to demonstrate the effectiveness of the changes made.

The practice had a schedule to assess and update practice risk assessments. The schedule included the frequency and date of assessment. We saw these had been completed on time.

Leadership, openness and transparency

Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns. Staff told us overall they were well informed of practice issues via team leaders and meeting records. However, some staff indicated they would have liked greater inclusion in the range of practice meetings that took place. Practice business meeting records demonstrated the practice leadership team were aware of this and had plans to address the issue.

We saw there were a range of regular meetings for individual teams. In addition the GPs met with nursing team every six to eight weeks and the reception team every 12 weeks.

Staff had access to on-going professional development opportunities and regular appraisal.

We saw evidence of changes to practice resulting from learning from incidents and significant events. For example, the electronic recording of who collected patient prescriptions as an audit trail in the event of lost or mislaid prescriptions.

The business partner was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. These were well organised, up to date and reflected current HR procedures.

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

The practice gathered feedback from patients through patient surveys, complaints and the patient representation

Are services well-led?

Good

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

group (PRG). The results and actions agreed from these surveys were available on the practice website. The practice had an active virtual PRG group mostly made up of representatives from a working age group.

We looked at the results of the PRG annual patient surveys (2013) and questions raised by patients to the group. The practice had responded to a range of comments including improving systems to enable patient contact with the practice during busy periods.

Staff told us they were able to give feedback and discussed any concerns or issues with colleagues and management. Overall staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available for all staff to read as guidance.

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated management lead through learning and improvement. For example, audit cycles were completed, action plans were reviewed and communication across the whole staff group took place. Learning took place through the review of significant events and other incidents and meeting records shared with staff via the practice electronic management and information system.

Staff told us and training records confirmed staff were able to remain updated with mandatory training requirements. We saw continuing professional development opportunities were supported. Staff files demonstrated regular appraisals took place which included a personal development plan.

New staff were supported via an induction programme and specific support to orientate and train them for their role.

The practice was a GP training practice for GP registrars specialising in primary medical care. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice.