Market Street Medical Practice

Quality Report

Market Street Medical Practice
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Market Street Medical Practice on 9 April 2015 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, safe, effective, caring, and well led services.

It was also good for providing services for the populations groups we rate.

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.
- Risks to patients were assessed and managed.
- Patients' needs were assessed and care was planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they could make an appointment with a named GP, with urgent appointments available the same day.
- The practice was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

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

The provider should:

- A programme of more frequent clinical audits should be developed to demonstrate positive outcomes for patients.
- Pre-employment checks should be in place before staff are employed.
- NICE best clinical guidance should be followed, for example, the review of warfarin.
- A planned programme of staff appraisals should be developed for clinical and non clinical staff.
- All staff clinical and non clinical should complete updated training in safeguarding children and adult protection appropriate to their role within the practice.

Summary of findings

- All staff clinical and non clinical should complete training in infection control and basic life support.
- The practice should develop a medicines cold chain policy.

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 to relevant staff members. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. 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 gaps in training had been identified and plans were in place to identify such gaps. Appraisals were planned and personal development plans for all staff needed to be developed. Staff worked with multidisciplinary teams. There was limited use of clinical audits used to improve patient outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services. 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. Staff treated patients with kindness and respect, and maintained confidentiality. Clinical staff were passionate and committed to providing good patient care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they usually got to see the same GP, there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. Information about how to complain was available on the practice website but this was not displayed in the patient waiting areas.

Are services well-led?

Good

The practice is rated as good for well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff

Summary of findings

felt supported by management. The practice had policies and procedures, but more needed to be developed. Systems and processes required further development. The practice sought feedback from staff and patients. Staff did not received annual performance reviews, though staff attended monthly staff 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. The practice participated in an 'Over 75 years project' where contact was made with patients to assess if support both medical or social was needed. Home visits to older people and people in care homes were provided. Nurse led Anti Coagulation clinic were held weekly. The practice kept a register of those patients over 75 years of age and all patients of this age had a named GP in line with the new GP regulations. The practice offered proactive, personalised care to meet the needs of the older people registered with the practice and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff ran long term and chronic disease management clinics. Longer appointments and home visits were available when needed. All these patients had a named GP and were reviewed annually. GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked well with midwives, health visitors and school nurses. Children attending the urgent walk in clinic were always seen and prioritised. Baby clinics were held once a week led by a GP. Nurse led immunisation clinics for young children were held weekly. Post-Natal checks for mums where postnatal contraception advice is stressed were also provided. Efforts to identify and educate young smokers and encourage attendance at smoking cessation clinics were in place. An in house 'Nexplanon' insertion contraceptive service led by the nurse was available.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. Services included early morning and late evening appointments and on-line appointment booking and prescription ordering. Access to alcohol screening, smoking cessation and support with weight management was promoted to enable patients to make healthy lifestyle choices.

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 of patients with a learning disability. Annual health checks were undertaken for this patient group and longer appointments were made available. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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. The practice worked effectively with community health services, for example, health visitors and school nurses.

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). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients in this group were offered longer appointments. During reviews mental health plans were discussed and agreed with the patients. Patients were screened for depression when they attended clinics. Counselling services were provided at the practice. The practice participated in the Dementia DES (Dedicated Enhanced Service) for one year from the 1 April 2014.

Summary of findings

What people who use the service say

We received 22 CQC patient comment cards and spoke with nine Patients.

We spoke with people from different age groups and patients from different population groups, including, parents and people with long term conditions. The patients we spoke with were complementary about the service. Patients told us that they were treated with respect.

Feedback included individual praise of staff for their care and kindness and going the extra mile.

Patients we spoke with told us they were involved in deciding the best course of treatment for them and they fully understood the care and treatment options that had been provided.

Patients told us that during consultations with GPs they felt listened to.

Patients were complimentary about nursing services provided at the practice. Describing staff as caring and attentive.

We looked at feedback from the GP national survey for 2013/2014. 393 surveys were sent out and 111returned, this is a 28% completion rate.

Feedback included; 56% of respondents would recommend this surgery to someone new to the area, in comparison to the local Clinical Commissioning Group (CCG) average of 75%.

89% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care, in comparison to the local Clinical Commissioning Group (CCG) average of 84%.

66% of respondents with a preferred GP usually got to see or speak to that GP in comparison with the local (CCG) average of 59% and 74% of respondents usually waited 15 minutes or less after their appointment time to be seen in comparison with the local (CCG) average of 65%.

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Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- A programme of more frequent clinical audits should be developed to demonstrate positive outcomes for patients.
- Pre-employment checks should be in place before staff are employed.
- NICE best clinical guidance should be followed, for example, the review of waifrain.
- A planned programme of staff appraisals should be developed for clinical and non clinical staff.
- All staff clinical and non clinical should complete updated training in safeguarding children and adult protection appropriate to their role within the practice.
- All staff clinical and non clinical should complete training in infection control and basic life support.
- The practice should develop a medicines cold chain policy.

Market Street Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience.

Background to Market Street Medical Practice

Market Street Medical Practice is located in Droylsden, within the Tameside Clinical Commissioning Group (CCG.) The practice was responsible for providing treatment to approximately 6000 patients.

The practice team comprises two male GPs and one female long-term locum GP. Two practice nurses, a healthcare assistant, a practice manager, and nine secretary/ receptionist staff.

All treatment rooms are located on the ground floor along with two patient reception areas. Rear access to the building is suitable for patients who use a wheelchair and there is a disabled toilet located close to the front patient reception area which also provides baby changing facilities.

The practice is open Monday to Friday, with variable opening times including an early morning surgery which commences at 7.30am on Tuesday mornings and late surgeries are provided on Monday's until 7.30pm and Tuesday and Friday till 6.00pm.

Appointments can be booked by telephone, in person, via the practice website, email and online. Appointments can be made up to two weeks in advance with a GP and up to four weeks in advance with the practice nurse or with the health care assistance. Walk in clinics were held three days per week between the hours of 8.30am and 10.00am, urgent on the day appointments only were available two days per week. All patients requiring urgent appointments are seen on the day, with children and older frail patients being given priority.

The practice has a GMS contract. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

When the practice is closed patients are directed to the out of hour's service provided by Go-To-Doc out-of-hours service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 April 2015. During our visit we spoke with a range of staff that included, GPs, practice manager, practice nurse and reception staff and spoke with patients who used the service. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We reviewed CQC patient comment cards where patients shared their views and experiences of the service.

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.

We reviewed safety records and minutes of meetings, which demonstrated that the practice had systems in place that provided an opportunity to review practices and procedures. Monthly practice meeting were held, as were monthly clinical meetings between the GP and practice nurses to look at incidents and respond to patient care needs.

The practice worked closely with Tameside Clinical Commissioning Group and attended monthly locality meetings and monthly practice manager forums. These meetings provided an opportunity for shared learning and discussion of significant events with other practices in the Tameside area.

Quarterly medication meetings were held with pharmacist advisors from the local clinical commissioning group (CCG) to ensure safe medication practice was followed and patient safety was upheld.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed four significant event reports. These included an analysis of the incident, actions taken and a lessons learnt. Significant events were discussed at practice meeting and clinical meetings. There was evidence that the practice had learned from significant events and findings were shared with relevant clinical and non-clinical staff.

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.

GPs received national patient safety alerts direct and other were disseminated by email to nursing staff and other practice staff. This allowed for shared learning and awareness.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a detailed and comprehensive child protection policy and followed Tameside Council safeguarding policy and protocol. The practice also had a detailed adult protection policy.

One of the GPs was the safeguarding lead for the practice. Staff told us they would approach the lead or any other GP in their absence if they had concerns about a patient. The lead was knowledgeable about the contribution the practice made to multi-disciplinary child protection work. Arrangements were in place to share safeguarding concerns with NHS and local authority partners and this ensured a timely response to concerns identified.

We looked at training records which showed that some clinical and non clinical staff needed to update their training in safeguarding children and in adult protection. The partner GPs were trained to level three. All staff clinical and non clinical should complete training in safeguarding children and adult protection appropriate to their role within the practice.

The staff we spoke had a clear understanding of when and how to raise safeguarding concerns and of their duty and responsibility to share concern with partner agencies, including local social services department and the police. However the practice did not display local contact numbers/flow chart for staff to follow in the event of a concern or the absence of clinical staff. We discussed this with the practice manager who took action and arranged for this information to be displayed in the staff reception area.

Within the patient record system there was an alert system which alerted GPs, nursing staff and reception staff to any ongoing child protection concerns and which also indicated that specific patients were to be seen only be the lead GP. Systems were in place to monitor children and vulnerable adult's attendance at accident and emergency departments or missed appointments.

The practice had a chaperone policy and this was displayed in the patient waiting area and in all treatment areas. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff,

a healthcare assistant and some reception staff acted as a chaperone when required. The practice had both female and male chaperones available. Reception staff confirmed they had completed chaperone training and other staff told us they were waiting to complete this training. Patients we spoke with were aware of this service but none had direct experience of it.

Medicines management

Systems were in place for the management of medicines including medicines management policies. The lead GP took responsibility for medicines management at the practice and worked with pharmacy support from the Clinical Commissioning Group (CCG) who visited the practice quarterly to review prescribing trends, for example, for antibiotics.

Emergency medicines for cardiac arrest were available within the building and were stored securely in the reception area. Records of monthly checks were maintained. We checked the emergency drug box and found two items to be out of date. We brought this to the attention of staff on the day of our inspection, who took action and immediately removed the items and this ensured safe patient care.

We saw other medicines, including vaccines, stored within the practice were in date and systems were in place to check expiry dates. Vaccine stocks were well managed and in date. The practice did not have a medicines cold chain policy. Fridge temperatures were recorded and monitored.

Patient medication recall systems were in place which allowed for annual medicine reviews to take place with a GP and changes recorded in patient's electronic records.

The practice had a member of staff who had responsibility for handing and responding to requests for repeat prescriptions. The member of staff was responsible for telephoning patients who requested a repeat prescription to check if they still required all the medicines requested. Patients we spoke with confirmed they had attended the practice for medicine reviews with a GP

The practice had guidelines in place for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. The practice processed repeat prescriptions within 48 hours. Patients we spoke with told us that requests for repeat prescriptions were dealt with in a timely way.

We saw prescriptions for collection were stored behind the reception desk. At the end of the day uncollected prescriptions were locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. Patients were asked to confirm their name and address when collecting prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness and infection control

Patients we spoke with told us the practice was 'always clean and tidy'. We saw that the practice was clean throughout and appropriately maintained and an infection control audit was last carried out in July 2014.

The lead GP at the practice had overall responsibility for infection control. We found the practice had a system in place for managing and reducing the potential for infection. An Infection Control Policy in place, along with protocols for the safe storage and handling of specimens.

We looked at staff training records and saw that a number of clinical and non clinical staff had not completed training in infection control and one newly appointed member of staff had not completed infection control training as part of their induction.

A cleaner was employed who undertook cleaning of the premises on a daily basis. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis.

We saw there was hand washing facilities in each surgery and treatment room, however sinks were not fitted with elbow taps and sinks had plugholes, plugs and overflows. Sinks in the practice did not conform to current infection control standards. Hand hygiene notices were displayed in clinical and toilet areas.

Flooring in nurses treatment rooms did not meet current infection control standards.

Protective equipment such as gloves, aprons and masks were readily available. Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin though not all had a date when opened recorded.

Good

Are services safe?

Disposable privacy curtains were used in all treatment areas and were labelled as to when they required replacing. A fabric screen was used in the nurses room and from reviewing cleaning schedules it wasn't possible to tell when this screen was last cleaned.

The practice did not use any instruments which required decontamination between patients and that all instruments were for single use only.

Equipment

A defibrillator and oxygen were available for use in a medical emergency. These were stored in the reception area and were in reach in the event of a medical emergency.

There were contracts in place for annual checks of fire extinguishers, portable appliance testing and calibration of equipment such as spirometers, used to help people breath. Checks were undertaken and records kept to evidence that equipment was maintained.

Panic buttons were located in clinical and treatment rooms for staff to call for assistance in the event of a difficult situation and there was an alert facility with the electronic patient record system which staff could use to raise an alert if they were in a difficult situation.

Staffing and recruitment

The practice did not have a recruitment and selection policy. We looked at the recruitment records of three members of staff who had been recruited in the last 12 months. We found that with the exception of one staff member all pre-employment checks had been taken up prior to employment. One member of staff had been in post since October 2014 and prior to their employment a Disclosure and Barring Service (DBS) check had not been taken up. We discussed this with the practice manager and partner GPs. We received evidence that a DBS check was applied for in respect of the member of staff on the 13 April 2015. We asked the practice to confirm what other action they had taken to ensure patient safety. The practice manager provided us with a copy of a risk assessment that had been completed in respect of the member of staff that included additional safety measures and ensured patient safety in the interim period. The practice was advised that for all future staff employed all pre-employment checks must be in place prior to employment.

As part of the quality assurance and clinical governance processes the practice did not routinely make checks of the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists to ensure that doctors, including locum GPs and nurses continued to be able to practice.

Safe staffing levels were maintained. Collectively three GPs provided a service to patients. There were nine receptionists, two practice nurses, a healthcare assistant, and a practice manager. Collectively the staff team were able to meet the needs of the patient population who were registered at the practice.

The practice manager and lead GP oversaw the rota for clinicians and this ensured that sufficient staff were on duty to deal with expected demand including home visits and daily patient demand for appointments including emergencies.

Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. This ensured adequate staffing levels were maintained at all times and this included the use of locums.

Monitoring safety and responding to risk

A review of practice minutes confirmed that safety and risk was monitored and discussed at meetings and measures were in place to discuss who had been admitted to hospital as an emergency. Clinical meetings were held monthly and provided an opportunity for peer review and to discuss patients with complex care needs.

Risk assessments were in place for known and identified risks, however these were not collated in one risk log.

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Carpet in the patients waiting area to the front of the building presented a trip hazard to patients, staff and visitors. The carpet was loose in two places and needed to be replaced or made safe. The practice manager took action and made arrangements for the carpet to be replaced.

The practice had a system in place for reporting, recording and monitoring significant events.

Good

Are services safe?

Staff had received training in fire safety and there was a nominated fire marshal for the practice. There was information in the reception and patient waiting area to advise patients what action to take in the event of a fire.

Some staff both clinical and non clinical needed to up date their training in basic life support (BLS). We discussed this with the practice manager who told us that BLS training was scheduled to take place in May 2015 for all staff.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. A business continuity plan was in place to deal with a range of emergencies that might impact on the day to day operation of the practice, for example, power failure, reduced staffing and access to the building.

The practice had an up to date fire risk assessment dated September 2014. The assessment identified areas of high risk that needed immediate attention, for example, checks to means of escape were not undertaken, fire drills not undertaken and an emergency fire exit was locked with a key and required a break bolt to be fitted. The practice did not have a fire log record book in which to record all fire safety checks, though weekly checks to the fire alarm system were recorded separately. The practice manager informed us on the 15 April 2015 that they had ordered a fire safety log record and had contacted a fire safety consultant to review requirements of fire safety for the practice.

Records showed that staff were up to date with fire training.

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 periodically.

Emergency medicines were available in a secure area of the practice and all staff knew of their location.

Patients were aware of how to contact the out of hours GP service and the practice website provided updated information for patients on this facility.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance form the Resuscitation council and calling 999 for patients where required.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided a service for all age groups including older people, people with learning disabilities, children and families, people with mental health needs and to the working population. We found GPs, nurses and other clinical staff were familiar with the needs of each patient group and the impact of local socio-economic factors on patient care.

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

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) though we found these were not always followed, for example, in respect of the management of warfarin. The practice ran their own warfarin dosing programme but they did not audit the results.

GPs and other clinical staff case managed and monitored patients with long-term health needs. The practice held clinical meetings where patients on the palliative care register were discussed.

Practice nurses and the health care assistant provided and managed a range of clinics, for example, asthma clinics, diabetes clinics, chronic obstructive pulmonary disease (COPD) reviews and new patient assessments. Patients with long term conditions were supported to self-manage, for example, diabetes. The practice was committed to health promotion and improving patient's life style.

The practice held a register of patients who had a learning disability and we were told that these patients were called for annual health checks.

Patients we spoke told us they were satisfied with the care and treatment they received. They told us they were included and had been consulted about treatment options.

The national Quality Outcome Framework (QOF) 2013/14 showed, 100% of the outcomes had been achieved for patients with arterial fibrillation and for patients with asthma 96.3% of the outcome had been achieved. However the practice fell below local and national average outcomes for patients with diabetes and Hypertension.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy and a 100% was achieved for maternity services.

Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails.

Management, monitoring and improving outcomes for people

We saw limited evidence of clinical audits that had been completed in respect of the practice. Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We spoke with the GP partners who told us that due to partnership changes over the past two years, coupled with managing the day to day delivery of the service and prioritising patient care, clinical audits had not been undertaken on a regular basis.

Processes were in place to recall patients with long term conditions, for example, annual asthma reviews, medication reviews and through the use of the national quality outcome framework (QOF).

Patients told us that GPs discussed and explained the potential side effects of medication during consultations.

The practice had a palliative care register and held multidisciplinary meetings to discuss the care and support needs of patients and their families.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

Patients with poor mental health were offered extended appointments to ensure they were unrushed and given the time to discuss their health concerns.

Information from the QOF 2013-2014 indicated the practice had maintained a level of achievement with 91.2% of outcomes achieved out of a possible 100%.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

The practice manager kept a record of training completed by GPs, practice nurses, health care assistant and non-clinical staff. Locum GPs were not included in this information so it was unclear if all staff at the practice had completed training, for example, in infection control.

Staff had up until the 31 March 2015 access to training, the majority of which was completed through e-learning. We were told that funding for staff training was no longer available and the practice was in the process of sourcing an alternative training provider. Staff told us they were able to access training and received updates when required. We saw that the majority of staff had completed mandatory training, for example, fire safety, but some staff needed to update training in infection control and basic life support and all staff needed to complete training in the Mental Capacity Act.

The majority of staff had not had an appraisal in the last two years with the exception of one of the practice nurses. We saw that appraisals were planned to take place in the coming months for other staff both clinical and non-clinical. Staff told us there were good informal support arrangements in place, staff told us they felt supported and there was a 'good team' approach across the practice, particularly in recent months with the confirmation of partnership arrangements and the appointment of new GP partner. Patient feedback also acknowledged that there had been a period of change with GPs at the practice and that they were happier to now see regular partner GPs at the practice.

All GPs took part in yearly appraisal that identified learning needs from which action plans were documented. All of the GPs in the practice complied with the appraisal process. GPs are required to be appraised annually and every five years undertake a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

All the patients we spoke with were complimentary about the staff. We observed staff to be competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to provide continuity of care for patients and ensured care plans were in place for the most vulnerable patients, for example, patients with a diagnosed mental illness. Multi-disciplinary meetings were held periodically to discuss patients with complex care needs, including end of life care.

For patients requiring support with alcohol or substance misuse the practice referred to local community drug and alcohol services and a range of voluntary organisations including the 'Smokers Quit Line' and Alcoholics Anonymous.

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, 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 had commissioned several directed enhanced services, (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) , including, dementia, health checks and minor surgery.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice.

Patients who required emotional support would be referred to counselling and bereavement support services.

Information sharing

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

Patients had the option of using local services through a 'local triage' service. This meant that patients could attend local hospitals and other venues to see specialists.

Information received from other agencies, for example accident and emergency or hospital outpatient departments was read and actioned by GPs on the same

Good

Are services effective?

(for example, treatment is effective)

day. Information was scanned onto electronic patient records in a timely manner. Systems were in place for managing blood results and recording information from outpatient's appointments.

All staff were required to sign a confidentiality agreement as part of their terms and conditions of employment at the practice. Staff fully understood the importance of keeping patient information in confidence and the implications for patient care if confidentiality was breached.

Consent to care and treatment

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. It was the practice that patients' verbal consent was recorded on their patient record for routine examinations.

GPs and clinicians ensured consent was obtained and recorded for all treatment. There was a practice policy for obtaining and documenting consent for specific interventions. It was the practice that for the majority of treatments patients gave implied or informed consent and arrangements were in place for parents to sign consent forms for certain treatments in respect of their children, for example, child immunisation and vaccination programmes. Where patients were under 16 years of age clinicians considered Gillick guidance. (This used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to. Clinical staff we spoke with had an understanding of the key parts of the legislation and were able to describe how they considered this in their practice and treatment of patients.

Patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted.

Translation services were available for patients whose first language was not English. When patients attended the practice they were asked if they needed a translator to assist during their appointment. Collectively these arrangements ensured that where language might be a barrier for a patient to understanding treatment and obtaining consent, patients were fully supported to make the right decisions that suited them.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. New patient checks included a review of the patient's lifestyle including family medical history and a review of their smoking and alcohol activity. The GP was informed of all health concerns detected and follow up appointments were arranged.

The practice was committed to health promotion and prevention with a strong emphasis on improving patient's well-being and lifestyle. Patients who smoked or who required assistance with diabetes management were provided with information about self management of their condition.

The practice also provided patients with information about other health and social care services such as carers' support.

The practice had systems in place that assisted in maintaining safe patient care, particularly in respect of patients over 75 years of age. The practice had an 'Over 75 years of age project', which involved practice staff contacting isolated patients, encouraging them to visit the practice and putting them in touch with voluntary support agencies, such as 'Silverline.'

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and there was a clear policy for following up non-attenders.

The practice kept a register of all patients with a learning disability and patients were offered an annual physical health check.

Written information was available for patients in the waiting area, on health related issues, local services and health promotion and carer's information, though this area would have benefited from other information, for example, how to make a complaint, safeguarding children and adults.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed staff speaking with patients respectfully throughout the time we spent at the practice. We observed reception staff speaking to patients in a respectful way and we heard staff during telephone discussions also speaking in a courteous manner.

We spoke with nine patients and reviewed 22 CQC comment cards received as part of our inspection. Feedback from patients was positive about the level of respect they received and dignity offered during consultations. Patients we spoke with told us they had enough time to discuss things fully with the GP and patients told us GPs listened to them. Patients told us they were fully involved in decisions made about any treatments recommended.

Facilities were available within the surgery and upon request for patients who wanted to speak in private. All patient telephone calls made to the practice were received into the back reception area which was private and telephone calls could not be overheard.

We looked at a sample of consultation rooms, treatment rooms and clinical areas, all areas had privacy curtains to maintain patient dignity and privacy whilst they were undergoing examination or treatment.

The practice offered patients a chaperone service. Information about having a chaperone was in the waiting area. Staff we spoke with were knowledgeable about the role of the chaperone and only clinical staff undertook this role. Patients we spoke with were aware that a chaperone service was available should they require a chaperone. Female and male chaperones were available.

Longer patient appointment times were available to patients who required extra time, for example, patients with mental health needs or learning disabilities. Early morning and late appointments were available to patients who worked.

Care planning and involvement in decisions about care and treatment

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

Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. They told us they felt listened to and time was taken to assist them to understand what was happening to them, they also said they were offered options to help them deal with their diagnosis.

Patients understood their care including the arrangements in respect of referrals to secondary care appointments at local and other hospitals and clinics.

Patients told us they usually got to see the same GP and they like this because if provided continuity of care.

GPs, practice nurses and the healthcare assistant ensured patients were involved in making decisions during appointments. We noted where required, patients were provided with extended appointments to ensure GPs and nurses had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

The practice monitored patients that had caring responsibilities. They were offered additional support and GPs were aware of local carer support groups that could be beneficial to carers registered with the practice.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team. Bereaved patients were referred to a counselling service.

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. We saw evidence of service planning and the provision of appropriate services for different groups of patients. The GP had a good understanding of their patient population and responded appropriately to patient need.

The practice offered a range of specific clinics through the GP and nurse appointment system, including diabetes reviews and COPD, (chronic obstructive pulmonary disease) reviews. Patients told us that their health needs were met whilst attending GP consultations and or nurse consultations.

The practice was proactive in making reasonable adjustments to meet people's needs, for example, providing home visits, booking extended appointments and sourcing translation services when required.

A repeat prescription service was available to patients, via post, by fax, on-line, via email and in person. We saw patients collecting repeat prescriptions at reception without any difficulties.

The practice worked with other health and social care professionals when providing palliative care.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice provided home visits for those patients who were too ill or frail to attend in person. GPs provided telephone consultations and extended appointments were made available for any patient who required additional time.

We saw that a ramp to the rear of the building provided disabled access for wheelchair users. There was also a ramp to the front of the building but patients told us that due to a raised door frame access could be difficult for people in wheelchairs. There were two patient waiting areas both of which were large enough to accommodate patients with wheelchairs and prams. Some patients complained about limited car parking facilities for disabled patients. There was a small car park located to the rear of the building and a public car park located across the road from the surgery, which provided disabled parking spaces.

The practice provided equality and diversity training through e-learning for all staff.

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

Access to the service

The practice opened Monday to Friday, with variable opening times including an early morning surgery that commenced at 7.30am on Tuesday mornings and late surgeries on Monday until 7.30pm and Tuesday and Friday till 6.00pm.

Patients could access appointments by telephone, calling into the surgery and on line via the practice website. Patients were able to make appointments in advance. On the day emergency appointments were available by telephoning the practice. Sick children and frail older patients were always seen. Longer appointments were also available for patients who needed them, for example, patients with mental health problems. The practice supported patients who lived in local nursing homes and care homes. Visits to patients in care homes was on a needs basis.

Information was available on the practice website that told patients about appointments, how to book appoints, including home visits and how to contact services out of hours. If patients called the practice when it was closed, an answerphone message gave information about out-of-hours services available.

From the CQC comment cards completed and speaking with patients we were told appointments were usually on time with not too much waiting. Though patients told us they could wait up to an hour when they attended emergency walk in clinics due to the popularity of this facility. GP appointments were provided in 10 minute slots the majority of patients told us that it was relatively easy to get an appointment.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. The practice manager was the designated responsible person who handled complaints in the practice. The practice manager was mindful to respond and deal with patient's complaints as they arose in an attempt to avoid complaints escalating. The patients complaints policy was not displayed in patient waiting areas, or detailed in the practice leaflet. However full details of how to make a complaint were made available on the practice website.

Patients we spoke with told us they knew how to make a complaint and they felt comfortable about making a complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver quality care and promote good outcomes for patients. The vision and practice values were part of the practice's statement of purpose. Staff we spoke with knew that the practice was committed to providing good quality primary care services for all patients, including the management of long term health conditions.

The practice had been through a period of change and development in the last two years that saw a change in the makeup of the GP partners. GPs told us that during this period their priority and focus had been on delivering good patient care. Historically locum GPs had been used regularly but this too had changed and the use of locums had decreased, when locums were used the practice ensured a core group of regular locums were used.

The partner GPs told us it was now their intention to develop systems and processes to ensure patients continued to receive good care.

We spoke with clinical and non-clinical staff during our inspection, all of whom told us that the practice was much more settled than previously. All staff were aware of the programme of change that the new partner GPs were striving to put in place.

Governance arrangements

The practice had some policies and procedures in place to govern day to day activity of the practice but others were not in place, for example, the practice did not have a recruitment policy . We looked at a sample of policies, for example safeguarding children, safeguarding adults and patient consent and saw these reflected up to date guidance and legislation.

There was a clear leadership structure and the lead GP took responsibility for medicines management and infection control, whilst a partner GP was lead for safeguarding across the practice.

Staff we spoke with were clear about their roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had some systems in place to identify, assess and manage risks related to the practice. Systems were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. These included monthly practice meeting and monthly clinical meetings.

However we found limited evidence of the use of clinical audits and how this was used to plan for patient care.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. There were systems in place to record performance against the quality and outcomes framework.

Leadership, openness and transparency

We observed that leadership was clearly visible across the practice and with established lines of accountability and responsibility.

The staff group had been through a number of changes over the past two years, including a change to the GP partnership make up with the addition of a new partner. Both staff and patients told us that things were much better now and stable. Staff told us they had seen improvements in communication, staff were staying and positive changes were occurring. Staff told us they enjoyed their work and they felt supported and there was good team work across the practice.

Staff told us they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

Seeking and acting on feedback from patients, public and staff

As part of its vision and values the practice planned to form and develop a patient participation group (PPG). We saw this was advertised within the practice and on the public website. Patients could also provide feedback on the service via email and through reporting concerns and making complaints.

The practice was taking part in the Friends and Family test. In response to feedback the practice had made a number of changes which included, the introduction of on line appointments, female toilet replaced and a shortened answer phone message.

Are services well-led?

Good

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

Monthly team meetings provided staff with an opportunity to feedback on how the delivery of the service was going, including what had worked well and if there had been any problems.

Individual staff performance and appraisal was not developed and staff had limited opportunity to provide feedback and to discuss their professional development and how this impacted and enhanced the day to day operation of the service.

Management lead through learning and improvement

The provider had systems in place to review incidents referred to as 'significant events analysis' (SEA) and other incidents, the findings of which were shared with staff at monthly staff meetings and clinical meetings to ensure the practice improved outcomes for patients and to provide an opportunity for learning from such events.

Quality assurance arrangements were limited and needed to be fully developed so as to ensure that performance and operation of the service was reviewed and monitored on a regular basis.

Annual appraisal and supervision arrangements were under developed. There was limited evidence to show how the continuing professional development of staff was maintained and what opportunities staff were provided with to undertake specialist training specific to their role.

The GPs were involved in local clinical meetings with the CCG and one GP led on medicines management at the practice.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge.