Dr KE Wilcox & Partners

Quality Report

The Medical Centre
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr KE Wilcox & Partners on 2 June 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing, effective, caring and responsive services. It required improvement for providing safe and well led services. The concerns that led to the practice requiring improvement for providing safe and well-led services applied to all the population groups. Therefore the practice requires improvement for the care of older people, people with long term conditions, for providing services to families, children and young people, working-age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, however reporting of incidents and near misses did not take place. There was no evidence of learning from incidents.
- Risks to individual patients were assessed and well managed but there was no systematic approach to clinical governance within the practice. There was no plan of audit for the practice.
- 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 training planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. Evidence of governance was sparse and there was limited evidence of communication; there had been no minuted meetings between partners during the past 18 months. There had been no staff meeting during the past 18 months.

There were areas of practice where the provider needs to make improvements.

Importantly the provider must:

- Ensure a systematic approach to reporting, recording and monitoring significant events, incidents and accidents.
- Ensure there are formal governance arrangements in place and staff are aware how these operate.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns and these were resolved without detriment to patients. However reporting of incidents and near misses did not take place. There was no evidence of learning from incidents. No incidents had been formally reported during the previous two years. Risks to patients were assessed and there were systems and processes to address these risks and risks to the practice and premises as a whole.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes, in most areas, were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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. There was evidence that appraisals were planned for staff and that consideration was given to their personal development.

Are services caring?

Good

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

Summary of findings

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 to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. The practice could provide no evidence of governance meetings or audits to monitor and assess patient outcomes. The practice could provide no evidence of 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

Requires improvement

The practice is rated as requires improvement for the care of older people. The concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed. For example the numbers of patients receiving the regular health checks for diabetes, chronic obstructive pulmonary disease and dementia that the guidance for the treatment of their condition indicated were well below the national performance. Longer appointments and home visits were available for older people when needed. The rate of influenza vaccination for patients over 65 years was better than the national average.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. Nationally reported data showed that outcomes for patients with long term conditions were mixed. For example the numbers of patients with diabetes, rheumatoid arthritis and asthma receiving the regular health checks that the guidance for the treatment of their condition indicated were well below the national performance. Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available when needed. However, not all these patients had a personalised care plan or structured annual review to check that their health and care needs were being met. The rate of influenza vaccinations for patients with long term conditions, whose condition meant that they were at an increased risk if they caught influenza, was better than the national average.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. However there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who were the subject of child protection plans. The practice's performance for child immunisations was excellent, sometimes achieving 100% of the target group and in every area outperforming the nationally achieved results, often significantly so.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement 

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students) because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. The practice offered a full range of health promotion and screening that reflected the needs of this group.

People whose circumstances may make them vulnerable

Requires improvement 

The practice is rated as requires improvement for the care of patients whose circumstances may make them vulnerable because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the care of patients experiencing poor mental health (including patients with dementia) because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. The practice informed patients experiencing poor mental health about how to access support groups and voluntary organisations. The percentage of these patients who had a comprehensive care plan documented during the previous 12 months was well below the national performance.

Summary of findings

What people who use the service say

We spoke with four patients on the day of our inspection. All the patients we spoke with were positive about the services they received from the practice and said they felt the care and treatment was good. Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. They said referrals to other services for consultations and tests had always been efficient and prompt.

Patients told us the appointments system worked well and they were able to get same day appointments if urgent. Some patients felt that it was still difficult to get through on the telephone despite the new telephone system. Patients told us they always had enough time with the GPs and nurses to discuss their care and treatment thoroughly, they never felt rushed and that they felt involved in decisions about their care.

We reviewed 4 comment cards completed by patients prior to our inspection. All of the comments were very positive and expressed satisfaction about appointments, the staff and being treated with care and consideration.

Information from the 2014 national patient survey showed that the practice results were, in most cases in line with the local and national results. Some areas had been rated well. For example, 71% of respondents said that they waited 15 minutes or less to be seen, compared to the local average of 60% and the national average of 65%. However only 47% of respondents found it easy to get through to the practice by phone, compared to 69% locally and 74% nationally.

Areas for improvement

Action the service MUST take to improve

- Ensure a systematic approach to reporting, recording and monitoring significant events, incidents and accidents.
- Ensure there are formal governance arrangements in place and staff are aware how these operate.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.

Dr KE Wilcox & Partners

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 and a practice manager advisor.

Background to Dr KE Wilcox & Partners

The practice is open between 8am and 6.30pm Monday to Friday. The practice is situated in an urban area of Sittingbourne but does cover some rural communities as well. It provides a service to approximately 8,500 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. The practice age demographics are similar to the national averages although it has approximately 35% more patients registered over the age of 65 and over the age of 75 than the national average. The figure for patients over 85 years is 27% more than nationally. Deprivation, including income deprivation, is marginally lower than that nationally. Unemployment is significantly less that nationally.

The practice has three partners, one male and two female. There are two female practice nurses. Regular locum GPs work in the practice on regular days each week and cover when the GP is on holiday. There are a number of administration staff, and a practice manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider Medway on Call Care (MedOCC) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

Dr KE Wilcox & Partners

The medical centre

32 London Road

Sittingbourne

Kent

ME10 1ND

Why we carried out this inspection

We inspected this service as part of our new 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.

This provider had not received a comprehensive inspection before and that was why we included them.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 June 2015. During our visit we spoke with a range of staff, including a partner GP, a practice nurse, a phlebotomist (a person who takes blood samples from patients) administration staff and the practice manager. We spoke with patients who used the services. We reviewed comment cards that patients had completed to share their views about the practice.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example they considered accidents, national patient safety alerts as well as comments and complaints received. Staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff. The staff were aware of their responsibilities to raise concerns. There was a policy to guide staff on what was a significant event. However not all staff knew about the policy. There had been no significant event reported over the two previous years.

Learning and improvement from safety incidents

There was no systematic approach to reporting, recording and monitoring significant events, incidents and accidents. There was an accident book, the last entry concerned an event that occurred in February 2014. There was no evidence of any learning from that event or of a systematic approach to learning. We found two occurrences that ought to have been classified as significant events. In each case the situation was dealt with efficiently and effectively but neither had been recorded as significant events.

We were told that there was informal discussion about significant events amongst the GPs and that some GPs might retain some records to use as part of their annual appraisal. There was no record of either the events or discussion about them available in the practice documents.

There was a process for dealing with safety alerts. These were received by the practice manager and passed to the GPs and nurses when the alerts were relevant. We looked at one recent alert concerning a medicine used for the relief of the symptoms of nausea. The alert advised that risk minimisation measures were necessary including restricted indications, use of lower doses, shorter treatment duration, addition of contraindications, warning and precautions. The practice had not searched the patient record to identify patients using the medicine but was relying on their prescriptions' clerk intercepting repeat requests for the medicine.

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 most staff had received relevant role specific training on safeguarding. For those who had not there was safeguarding training arranged. 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.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in child safeguarding to the appropriate level (level three). All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. We talked through examples of safeguarding incidents and were satisfied that the staff had responded correctly.

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

There was a chaperone policy. There were posters about chaperoning displayed on the waiting room noticeboard but they were not on display in the consulting rooms. There were sufficient staff trained to act as chaperones there had been recent training for chaperones and further training was planned.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, temperatures were recorded. The fridges were not hard wired into the electrical system but run from on an extension lead from a socket. The chances of the fridges being accidently unplugged were therefore increased. There was a stock control process to ensure that 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 patterns of hypnotics, sedatives and anti-psychotic prescribing were within the range that would be expected

for such a practice. The nurses administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. There was evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

The premises were clean and tidy. The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were well stocked with personal protective equipment (PPE) including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice. The premises had recently been refurbished and met the most recent infection protection control standards.

The practice had a lead for infection control who was qualified to provide advice on the practice infection control and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. Audits had been carried out and these had identified necessary changes such as the number of sharps boxes that were needed across the practice. These measures were being actioned.

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, PPE was available to staff and staff were able to describe how they would use the equipment to comply with the practice's infection control policy such as the use of disposable couch coverings and the treatment of hazardous waste.

The practice had recently engaged a cleaning contract company with specialist expertise and experience in cleaning medical facilities. We saw there were cleaning schedules and cleaning records were kept. We saw that, for example, the privacy curtains around the couches were disposable and had stickers indicating when they should be changed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and there was a schedule for ensuring that it was done when required.

Staffing and recruitment

Personnel records confirmed that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and criminal record checks through the Disclosure and Barring Service (DBS). Where staff lacked training or were awaiting outcomes such as DBS checks there were notes available to staff to help ensure they were not used for those tasks. For example for certain clinics the receptionists had records showing "(name) not to be used until training completed". All GPs, nurses and staff who acted as chaperones had had criminal records checks. There were records to show that the professional registration checks for staff with the Nursing Midwifery Council or the General Medical Council had been completed.

We saw there was a rota system in place for all the different staffing groups to ensure that there were enough staff on duty. The rota system ensured that staff, including GPs, nurses and administrative staff covered each other's annual leave.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. A fire risk assessment had been undertaken that included actions required to maintain fire safety. Following the assessment the practice had installed a new fire alarm system.

There was a system governing security of the practice. For example there was a localised CCTV system and electronic front door lock so that staff, who on occasion in the evenings were alone in reception, could see who was at the door before letting them in. Visitors were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied and the door shut to prevent unauthorised access. There were key pad locks to all the doors where the patients might gain access.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic

life support (BLS). The emergency trolley in the treatment room was up to date and adequately equipped including medical oxygen. Staff knew the location of this equipment. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We checked the emergency medicines, they were in date and reviewed regularly.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. There were local contingency plans for outbreak of disease for example, Ebola.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment followed national best practice and guidelines. For example, the emergency medicines and equipment held by the practice were consistent with the guidelines issued by the Resuscitation Council (UK). The GPs and nurses used the guidelines from the National Institute for Health and Care Excellence (NICE) and local guidelines to deliver treatment in line with current best practice. Staff used the practice's patient records system to access NICE guidance. Staff also used local guidelines and referral pathways that had been produced by the local clinical commissioning group (CCG).

There was a range of nurse appointments available to patients through a number of clinics for chronic disease management – such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). There were GP leads for specialities such as diabetes. Data showed that the practice's performance for antibacterial, hypnotic and pain killer prescribing was comparable to similar practices. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

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, managing child protection alerts and medicines management.

There had been some prescribing audits carried out in cooperation with the local prescribing advisors. The practice was amongst the six best practices, in prescribing terms, in the CCG. However the results of audits were not always shared with relevant staff. There was no overall audit plan for the practice. There was no evidence of a structured approach for example, audits aimed at improving care for the practice's larger patient groups.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice used the information collected for the QOF and reviewed performance against national screening programmes.

The QOF results indicated that the practice often achieved very highly in terms of diagnosing patients with illness such as depression, hypertension, cancer and rheumatoid arthritis. In this regard the practice was amongst the best in the area. Also evidence showed that this performance had been sustained over a number of years. The practice was aware when this aspect of performance had fallen. For example the diagnosis of new cases of depression was below the level the practice expected in 2012 and 2013. The practice had reviewed how depression was recorded and undertaken a significant initiative to diagnose new cases. The practice had raised its effectiveness in diagnosis of depression so that it was in the top 20% in the country. For the 22 common conditions measured by QOF, the practice was above the national average in its diagnosis for 15, most of the remainder were only marginally below the national averages.

However the QOF results also showed a lack routine management of disease in the same areas. For example, in some the areas relating to the routine management of disease the practice had experienced a severe drop in performance. This drop in performance was most noticeable in indicators which required the practice to administer a test or check some function of the patient within the last 12 (or sometimes nine) months.

For patients with chronic obstructive pulmonary disease, those who had had an annual review, with a healthcare professional, had fallen from 87% to 68% between 2012 and 2014. This placed the practice in the bottom 5% of practices in the country. For patients with diabetes, those receiving a foot examination, usually an annual assessment, the figure had fallen from 91% to 81% between 2013 and 2014. Similar performance was seen across the management of rheumatoid arthritis, asthma and hypothyroidism. For patients with hypertension who were given lifestyle advice the percentage had fallen from a very creditable 99% in 2012 (among the top 10% of practices nationally) to 80% (in the bottom 33%) in 2014. Again for patients experiencing poor mental health the percentage had fallen from 92% in 2012 in the top half of

Good

Are services effective?

(for example, treatment is effective)

practices nationally to 60% (in the bottom 10%) in 2014. Together these results seemed to indicate that patients were not having the checks at the standard intervals that the guidance for the best management of their disease indicated.

The practice was aware of its own performance, some of which they believed was attributable to errors in how consultations had been coded into the computer system, rather than reflecting the service given to patients. However the practice was determined to improve and one of the partners had taken on responsibility for performance in QOF. The practice had also recently begun using a bespoke computer application designed to follow up on patients' annual reviews. They reported that these measures had already led to improvements.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. We were told that some of the GPs had completed their revalidation and other GPs knew when there revalidation was due. All GPs and nurses were appraised annually.

There was a new practice manager and annual appraisals had not been completed for administrative staff. However, the staff had received a pre appraisal questionnaire, aimed at identifying training and development needs as a preliminary to the formal appraisal process. The practice had a planned approach to training for staff. There was a record which showed staff and the training they had received. The records showed that essential training such as basic life support and safeguarding had been completed by all staff. Nurses had received training in the management of the long term conditions they cared for in their clinics. Staff we spoke with told us of training that had been discussed with managers and agreed although it had not yet been delivered.

Working with colleagues and other services

The practice worked with other professionals such as, district nurses, social services, GPs and other specialists. The practice made referrals by letter and fax and electronically. Referrals were sent to secretarial staff for dictation and returned to GPs. The practice had plans to use the choose and book system, the national service that combines electronic booking and a choice of place, date and time for first hospital or clinic appointments, whenever possible. A date had been set for the launch of this.

The practice received test results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were processes to manage this correspondence and staff understood their responsibilities in relation to these. There were three GPs tasked to check results so that the results were addressed promptly. There was a "buddy" system so the GPs covered each other's commitments when a GP was absent.

The practice did not hold multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. GPs and nurses contacted the relevant professionals such as district nurses or social workers when there was a need.

Information sharing

All information about patients received from outside of the practice was captured electronically in the patients' records. For example, letters received were scanned and saved into the patients' records by the practice. The practice had systems to provide staff with the patient information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff were trained in the use of the system. Staff we spoke with liked the system, saying it was easy to use. There was software that enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and provided guidance for staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent was recorded.

Most staff had undertaken training in the Mental Capacity Act 2005. Staff who had not had formal training were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff. Mental capacity

Good

Are services effective?

(for example, treatment is effective)

assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support.

Health promotion and prevention

All new patients were offered a health check. They were given a questionnaire and an appointment with the nursing staff which included a new patient check. Those on repeat medications were referred to the appropriate specialist nurse appointment in the first instance and to a GP if necessary. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were told of several instances where these checks had led to the early diagnosis of long term conditions.

The practice had numerous 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. They were all offered an annual physical health check. The practice supported a number of patients in residential homes for the elderly and a women's refuge for women who were suffering abuse, these services were allocated a GP and this assisted with continuity of care.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was excellent, sometimes achieving 100% of the target group and in every area outperforming the nationally achieved results, often significantly so. The same was true for vaccinations for patients over 65 years and for patients under 65 whose condition meant that they were at an increased risk if they caught influenza, where the practice's performance was better than the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and information from the patients submitted to the practice under the recently instituted NHS "friends and family" test. We spoke with patients and read the comment cards that had been completed. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

A number of questions in the national patient survey covered the care patients received in the practice. The responses to these questions were all close to or above the local clinical commissioning group averages. The answers also showed that patients felt GPs and nurses were good at listening to them, explaining tests and results and giving them enough time to discuss their care.

Patients completed four CQC comment cards to tell us what they thought about the practice. We also spoke with four patients during our inspection. Both the comment cards and what the patients said were positive. There were no negative comments concerning care. It showed that patients felt they were satisfied with the care provided by the practice and said that their dignity and privacy were respected.

All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard. The rooms were, if necessary, fitted with window blinds. The consulting couches had privacy curtains and patients said that the doctors and nurses closed them when this was necessary.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. The reception area was aside from the waiting area so that patients' conversations with the receptionists were confidential as were telephone calls coming into the reception. There was guidance for the reception staff on how to keep information confidential and how to deal with requests for information. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour, or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There was a notice, visible on arrival at the practice, stating the practice's zero tolerance of abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients said that the GPs and the nurse discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive. They said that staff explained the care and treatment that was being provided and what options were available. Patients also received appropriate information and support regarding their care or treatment through a range of informative leaflets. The patient record system used by the practice enabled GPs and the nurses to print out relevant information for the patient at the time of the consultation.

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. Data from the national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 63% felt the same about the nurse who spoke with them. Both these results were in line with the results locally and nationally.

Patient/carer support to cope emotionally with care and treatment

There was support and information for patients and their carers to help them cope emotionally with their care, treatment or condition. We heard reception staff explaining to patients and their carers how they obtain access to services such as those related to specific disabilities or conditions. The practice cared for a number of learning disability homes. Reception staff were careful to help patients with learning disability, they helped with administrative issues such as when someone needed to re-order medicines, on occasion they called the homes to ensure patients were aware of their appointments and arranged transport such as taxis.

There was no protocol for staff to follow to help identify carers although carers were identified by individual staff if an opportunity arose. The carers were identified on the patient record system so that staff were aware of them and could offer help if necessary. Staff were aware of the local

Good

Are services caring?

organisations who provided help for carers. There was no protocol to guide staff when dealing with bereavement.

Individual GPs decided what assistance would be offered. Generally GPs called the family and offered their condolences together with a consultation at a place convenient to the patient if this was requested.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood. The practice was able to respond flexibly. For example following feedback about the appointments system, the practice had reviewed it. They had brought in a new system which allowed patients to book five weeks in advance as opposed to only two weeks in advance.

We heard staff making appointments. They were pleasant and respectful to the patients. They tried to accommodate the times that the patients asked for however, when they could not they talked with the patients to identify other suitable times. Patients had the choice of male or female GP. There were longer appointments available to patients who needed them. The computer system flagged those who had already been identified as needing longer appointments. Receptionists told us they would book longer appointments if so requested and we heard them doing this. Receptionists had flowchart which guided them on how long different appointments should be for example 30 minutes with the nurse for a "new" diabetic appointment and 15 minutes for other specific tests.

Interest in the practice's patient participation group had fallen off over the last year. However, the practice had identified five patients who were interested in restarting the group. The practice was fixing dates for the first meetings of the new group.

Tackling inequity and promoting equality

Disabled patients could access the practice. There was a ramp leading to the front door so that patients in wheel chairs could use it. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was a toilet with access for the disabled as well as mother and baby changing facilities. Staff told us that patients who were homeless could be registered as temporary patients using the practice address but that there had been no call for this recently.

Access to the service

The practice was open for surgery hours 8 am – 6 pm Monday to Friday. Each GP had three "emergency appointments" each day. If these filled up then the reception staff would inform the GPs who triaged the requests to determine which patients needed immediate attention. The decision to see emergency patients was a clinical decision made by the duty GP. If the emergency appointments were not filled during the morning then they were released to provide additional routine appointments. A similar process was applied so that afternoon emergency appointments were available. The practice provided a telephone consultation service for those patients who were not able to attend the practice.

The GPs carried out home visits if patients were housebound or too ill to visit the practice. There were appointments available outside of school hours. Children of school age were given appointments on the day the parents rang if requested. There were arrangements to help 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. Details of how patients could access services outside of opening times were displayed on the front of the building.

Longer appointments were available for people who needed them. This also included appointments with a named GP or nurse. Nurses called on housebound patients to undertake checks. For example, for patients with long term conditions that would normally have been seen at the practice clinics. Patients were generally satisfied with the appointments system. They said they could see a doctor on the same day if they needed to. We heard the reception staff making appointments that afternoon for patients who called during the morning. There were only four patient comment cards, some of these cards, and the reviews on NHS Choices, felt the new telephone system was an improvement. However other patients still felt that it was difficult to make appointments.

Listening and learning from concerns and complaints

The practice had a system for handling concerns and complaints. This system had been introduced by the new practice manager within the last year. The practice manager was designated to handle all complaints in the first instance. Information was available to help patients understand the complaints system. There were posters and leaflets clearly displayed in the practice which explained the complaints system. There had been three complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

since the introduction of the new system. In each case the practice manager had written to the complainant for further information but had not received a reply. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with said that they had ever needed to make a complaint. They did say that they felt that if they did have to make a complaint they would be listened to and the matter taken seriously.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice leadership explained that, in the past, the practice had failed to keep up with the changes that were impacting on general practice. This had come to a head about 18 months ago when it became clear that the practice could not continue without significant change. A new practice manager had been employed and a three year improvement programme began. Staff were aware of and involved in the programme. The staff we spoke with told us they felt well led and described a practice that was open and transparent. Staff consistently said they understood the practice objective namely, to become one of the top three practices in the locality. The GPs and the manager said they advocated an "open door" policy and all staff told us the GPs and practice manager were very approachable.

There had been discussion amongst the GPs and staff about the strategic direction of the practice and there had been informal discussions with other health professionals about how the practice might develop. For example the practice was party to early talks about federating with other practices within the local clinical commissioning group (CCG).

Governance arrangements

There was a range of mechanisms to manage governance of the practice. The policies we looked at were adequate though many needed to be brought up to date. The practice told us that a review of policies was part of this year's work in the improvement plan and we saw that this work had already begun. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a lead for safeguarding, for education and for human resources. Staff knew who the leads for the roles were and were confident in approaching them if necessary.

Staff told us that they felt involved in the changes that had happened over the last 18 months. They said they were informed through regular discussion with the practice manager. However there had been no formal staff meetings over that period.

We were told that the GPs regularly talked through difficult cases with each other and there had been changes to the care that individual patients received as a result of this.

These changes were recorded on the patients notes but there was no system to help ensure any learning from these discussions was shared across the practice. The practice used the Quality and Outcomes Framework (QOF) to monitor the effectiveness of the care and treatment provided to patients. Some QOF results, such as those that reflected the practice's diagnosis of specific diseases and conditions, were excellent. In other areas, such as the numbers of patients receiving regular health checks for common conditions for example asthma and diabetes, the results were below what the practice could expect to achieve. The practice was aware of this. A partner had been delegated to monitor and to improve the QOF results. The practice had purchased an advanced software system to track and improve the outcomes.

There was no evidence of clinical governance meetings. There was no peer review of GPs decisions such as referrals to secondary care. There was no evidence of partners meetings. There was no evidence of practice meetings. There were no multidisciplinary team meetings to discuss the needs of complex patients. There was no planned approach to auditing. There was no systematic approach to the management of significant events and there had been no reported significant events.

The practice had arrangements for identifying, recording and managing risks in relation to the premises and its staff. Routine checks were undertaken and any risks were identified and recorded. Risk assessments had been undertaken, for example, a fire risk assessment. The practice regularly monitored the premises itself and this included processes and procedures in relation to patient safety and the general management of the practice.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. Staff had responsibility for different activities for example, checking on QOF performance.

The leadership of the practice had achieved a great deal during the previous 18 months and recognised that there was still much that needed to be improved. Achievements had included: the complete refurbishment of the building

Are services well-led?

Requires improvement

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

making it compliant with latest hygiene standards, making the practice information technology literate with staff using IT for financial, administrative and patient management matters, as opposed to paper systems. New leads had been identified for the important functions such as finance, human resources and patients' care. A new telephone system had been installed, with extra telephone lines, and a new appointments system brought in. The practice recognised that the areas that needed to be improved included clinical governance, staff appraisal and training and the modernisation of policies and protocols, including the staffs' knowledge of them.

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

Staff we spoke with felt that the practice was open to suggestions from staff. They said they were made aware of comments and planned changes through regular emails from the practice manager. During the refurbishment of the premises the staff had been consulted over the layout of the new reception area and their comments had been acted on. We were told that the practice had responded to patients' suggestions concerning the layout of the new waiting room and the type and availability of patient information leaflets however there was no patient participation group.

Management lead through learning and improvement

The practice GPs and nursing staff accessed on-going learning to improve their clinical skills and competencies, for example, attending specialist training for conditions such as diabetes and asthma. GPs and nursing staff attended external forums and events to help ensure their continued professional development. Staff had protected learning time during the monthly half-day closure of the practice set aside for learning and development.

Administrative staff told us that the practice supported them in their personal development, for example the identification of a staff member to be trained as a phlebotomist (a person who takes blood samples from patients). There was a plan to improve on staff training and the roles of staff had been reviewed as part of the reorganisation of the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to establish and operate effectively systems to: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) Because: (1) There no systematic approach to reporting, recording and monitoring significant events, incidents and accidents, (2) There was no system for monitoring the quality of the experience of patients in receiving those services and (3) There was no systematic approach to clinical governance.