St James Medical Centre

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

St James Medical Centre has a patient population of approximately 5,800 patients. The practice is located in a converted house. We visited the practice on 21 May 2014 as part of this inspection.

We spoke with ten patients during the inspection and received feedback via comment cards from eight patients. We met the chair of the Patient Participation Group (PPG). We spoke with staff including three GPs, two nurses, a health care assistant and a receptionist.

Patients received safe care. Learning from incidents took place to improve safety. Staff received training in safeguarding and were aware of how to report any suspicion of abuse. Staff were provided with training in medical emergencies. Patients were protected from avoidable harm.

The practice provided effective care and treatment that met patient needs. Clinical guidance was referred to and followed by staff.

Staff were aware and responsive to patients' needs. The premises restricted some patients' ability to access the premises independently. GP partners were working towards a solution to address the accessibility restrictions. The appointment system caused some patients problems, specifically when trying to book appointments for the same day.

We found patient feedback was sought and responded to. Complaints were investigated robustly and responded to promptly. The last patient survey did not raise any concerns regarding the appointment system.

Staff were considerate, respectful and courteous with patients. Confidentiality and privacy were maintained by staff.

Staff told us there was an open culture where feedback was encouraged and acted on. Communication between staff was facilitated through regular meetings. There was effective monitoring of the service which identified and responded to concerns and identified improvements. However, some learning was not communicated to staff when improvements were identified.

The practice did not ensure patients were protected from the risks associated with unsafe or unsuitable premises because the design and layout of the building was not suitable to ensure safe access. The service was not meeting the essential standards of quality and safety. We have issued a compliance action.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. The service was pro-active in identifying and responding to safety risks. Incidents were reviewed and action identified where the service could improve safety. Staff were trained in how to identify and respond to potential abuse in vulnerable adults and children, as well as medical emergencies. Emergency medical equipment and drugs were available. Checks were in place to ensure patients and staff were protected from the risks of infection and inappropriate storage of medications. Recruitment procedures ensured staff were of good character, qualified and competent to carry out their roles and meet the needs of patients.

Are services effective?

The service was effective. Care and treatment met patient's needs. The practice referred to and used national best practice in providing care and treatment. Some patients with complex needs were discussed with external professionals to ensure they had adequate and consistent support from different services. Patients were supported to live healthy lives and manage their health and wellbeing independently.

Are services caring?

The service was caring. Patients were treated with respect, dignity and courtesy by staff. Their privacy and confidentiality was respected. Staff provided choice and involved patients in decisions about their care and treatment.

Are services responsive to people's needs?

The practice was responsive to patient's needs. We found staff assisted patients with limited mobility and adjustments were made to the premises to improve access. The practice was considering what action could be taken to improve physical access for patients. The appointment system caused problems for some patients to access appointments on the same day. Although staff were aware of the ethnic diversity in the area the service had not assessed what measures could improve access for patients from specific ethnic minorities or cultures who may require additional support. There was a thorough process for dealing with and responding to complaints from patients.

Are services well-led?

The service was well led. The service had an open culture which encouraged staff and patient feedback. We found feedback provided by staff and patients was acted on. There were meetings for all staff

Summary of findings

to communicate with each other. However, we found some key information was not provided to staff to ensure improvements to the service were made. The practice identified, responded to and managed risks to safety and quality effectively.	

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
Health promotion was provided to older patients through specific immunisations, information and advertising of external services. Accessibility to the surgery could be difficult for older patients with mobility issues but staff were supportive and responsive to patients who required assistance.

People with long-term conditions
The service provided periodic reviews for patients with long term medical conditions. Some annual checks for patients were not completed but the practice had taken action to remedy this concern.

Mothers, babies, children and young people
Appointments for pre-natal and antenatal check-ups were available. We found a concern about the responsiveness of the practice in booking an appointment for an unwell child.

The working-age population and those recently retired
Access to appointments for patients had been improved due to feedback from the annual survey. However, a lack of access to the telephone system meant patients who worked may find it difficult to book an appointment. We were told that it was difficult to get same day appointments.

People in vulnerable circumstances who may have poor access to primary care
Staff were provided with safeguarding training and were aware of how to identify potential abuse and report it. The service did not provide a translation service for patients who did not speak English.

People experiencing poor mental health
Information which may have been useful to patients with mental health problems was not available in the waiting area or on the practice website.

Summary of findings

What people who use the service say

We spoke with 10 patients and received feedback from eight patients via comment cards left in reception during the inspection. Patients told us the practice met their needs. They told us they were involved in decisions about care and treatment, and provided with choice where possible. They were complimentary about the attitude of staff, commenting that they were courteous, respectful and caring. Patients we spoke with were concerned about the difficulty in phoning receptionists and accessing appointments on the same day. There were 14 comments in the 2014 patient survey, which had 268 respondents, about difficulties when calling the practice for an appointment early in the morning.

Areas for improvement

Action the service MUST take to improve

- The practice must ensure that access is improved for people with disabilities, restricted mobility and families with young children.

Action the service COULD take to improve

- The practice could consider ways to improve patient's access to appointments.
- A recognised audit tool could be implemented to ensure any infection risks are identified and acted on.
- Communication amongst staff, specifically between GPs and nurses, could be improved.

St James Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector, a GP specialist advisor and an expert by experience. Experts by experience are people who have expertise because they have either cared for people using services or have experience in using services themselves.

Background to St James Medical Centre

St James Medical Centre is located in Tunbridge Wells. The practice occupies a converted house. The practice provides a range of primary medical services to approximately 5,800 patients. Patients are supported by a number of GPs, nurses, health care assistants, a practice manager and administration staff. The practice is a member of the West Kent Clinical Commissioning Group (CCG).

St James Medical Centre, 11 Carlton Road, Tunbridge Wells, TN1 2HW

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting we checked information about the practice before the site visit on 21 May 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff, patients and a representative of the Patient Participation Group (PPG). We looked at audit outcomes and actions taken to improve the service. We checked to see if complaints were acted on and responded to. The premises were inspected to ensure they were safe. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Are services safe?

Summary of findings

The practice was safe. The service was pro-active in identifying and responding to safety risks. Incidents were reviewed and action identified where the service could improve safety. Staff were trained in how to identify and respond to potential abuse in vulnerable adults and children, as well as medical emergencies. Emergency medical equipment and drugs were available. Checks were in place to ensure patients and staff were protected from the risks of infection and inappropriate storage of medications. Recruitment procedures ensured staff were of good character, qualified and competent to carry out their roles and meet the needs of patients.

Our findings

Safe patient care

Staff we spoke with were aware of how to report incidents and events which could put patient safety at risk. This enabled staff to be proactive in identifying, reporting and taking action to reduce the risk to patient safety. The significant event log and saw there was a good record on patient safety over the previous 12 months. Staff told us they were alerted to any significant issues regarding patient welfare via alerts on the patient record system. This allowed staff to ensure they considered what safety issues may affect the care they provided to patients. For example, patients with a cancer diagnosis would have an alert for staff on the system so that staff could consider this when the patient was seen.

Learning from incidents

We looked at the significant events log for the practice to review how incidents were reported and investigated. We saw that events which had the potential to impact on patient safety were investigated by the practice and discussed at staff meetings. Action was taken to address any risks identified from investigation of events. We saw meeting minutes which indicated that staff periodically discussed significant events at meetings to ensure that any learning from events was communicated properly and reflected the day to day working of the practice. The practice had processes for ensuring that any incidents which could affect patient safety were acted on and any learning required by staff was communicated to reduce the risk of similar incidents reoccurring.

Safeguarding

We saw a training log showing the practice provided staff with safeguarding vulnerable adults and children training. Clinicians had the opportunity to attend external training and all staff attended internal safeguarding training delivered by the manager. The manager used a training tool to deliver internal training to staff. We saw a policy on safeguarding children but there was not one for safeguarding vulnerable adults. Staff we spoke with were aware of indicators of potential abuse for both adults and children and knew who the practice safeguarding lead was. The practice made a safeguarding referral to the local social care team regarding a child within the last year due to concerns identified by staff. The practice had a

Are services safe?

whistleblowing policy for staff to refer to if they needed to report concerns about the practice internally or externally. Staff knew their responsibilities in keeping patients safe from harm and reporting any suspicion of abuse.

Monitoring safety and responding to risk

The practice was effectively monitoring risks to patients and staff. There was a control of substances hazardous to health (**COSHH**) risk assessment available for all the chemicals used by the cleaners. The assessment was readily available for staff to refer to if required. This meant the risk when using hazardous chemicals was reduced and there was information available on chemicals stored in the event of spillages or a fire. The practice manager told us staff undertook fire warden training to ensure they were aware of their responsibilities in keeping patients safe in the event of a fire. They also told us that a fire risk assessment of the premises was due to take place during the summer.

Medicines management

We looked at medicines and medical equipment stored in the nurse's treatment room. We found all medical equipment and drugs were within expiry dates. A nurse told us any drugs that were due to expire within two months were marked with a highlighter to indicate a replacement had been ordered. We saw emergency medicines were within expiry dates. Fridges were monitored to ensure they remained within the correct temperature ranges for the drugs stored in them. Records were kept to indicate the fridge temperatures were checked frequently. A nurse told us that reception staff had been trained on how receive deliveries of drugs that required immediate storage in the fridge. She explained how the process worked to ensure the cold chain for such drugs was maintained. Medicines were managed safely by staff to ensure their effective and safe use.

Cleanliness and infection control

We found the practice was clean and hygienic. We saw regular cleaning checks took place and were recorded. Clinical rooms were free from dust and dirt on all surfaces. Treatment rooms and toilets had appropriate hand washing facilities and were well stocked with paper towels and liquid soap. Separate cleaning equipment was used in different areas of the practice to reduce the risk of cross-infection. There was no hygiene and infection control audit tool used to monitor hygiene and infection control. Audits would assist the service to meet guidance and identify risks related to hygiene and infection control. However, we saw staff were pro-active in identifying infection control risks. For example, the manager had implemented a system to reduce the risk of infection potentially posed by patient samples. Staff were aware of their responsibilities regarding hygiene and infection control, but there was no formal training to ensure staff followed relevant guidance related to infection control. Staff were given information on hygiene and infection control. For example, a procedure for staff to follow in the event of a sharps injury was displayed in treatment rooms. Staff were pro-active in following hygiene and infection control guidance to protect patients and others from the risk of infection. Patients were cared for in a clean environment.

Staffing and recruitment

We looked at the staff records for two members of staff who had started working for the practice within the last year. We saw they had Criminal Record Bureau (CRB) or Disclosure and Barring Service (DBS) checks, references from previous employers in health or social care and employment histories. The practice manager explained some locum GP references were verbal and not recorded so they could not be shown to us. We saw GP's certificates of enrolment on the Medical Performers List (required for all doctors to practice) for permanently employed GPs and regular locums. The manager implemented a new recruitment process in 2013 which meant a standardised process during recruitment was followed. This ensured appropriate checks were undertaken on staff to ensure they were safe to work alone with patients and this information was stored by the practice to evidence the checks were undertaken.

Dealing with Emergencies

We saw the practice had a business continuity plan for events such as bad weather or loss of utilities which could potentially impact on the safe running of the service. This was displayed in the manager's office for staff to refer to if required.

Emergency medicines and equipment were stored on site. We saw an oxygen cylinder and this was within its expiry date. We saw records of staff training in dealing with medical emergencies which showed this was undertaken annually. A newly inducted staff member said they were shown where emergency medical equipment and drugs were stored.

Are services safe?

Equipment

We saw equipment was in good working order. Maintenance records were available for safety equipment such as fire extinguishers and the fire alarm system. Patients were protected from the risk of unsafe equipment.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment met patients' needs. The practice referred to and used national best practice in providing care and treatment. Some patients with complex needs were discussed with external professionals to ensure they had adequate and consistent support from different services. Patients were supported to live healthy lives and manage their health and wellbeing independently.

Our findings

Promoting best practice

The practice undertook clinical audits regularly. Some were part of a cycle of audit, some in response to concerns or issues identified and some in response to GPs annual appraisals. We saw audits reflected national best practice and guidance such as national institute for health and clinical excellence (NICE) guidance in their findings. One audit from 2013 resulted in a change in prescribing of specific drugs to reflect recent changes in national guidance. GPs and the practice manager told us audit findings were shared amongst clinical staff through meetings. A member of clinical staff told us it was their responsibility to ensure they followed national guidance. This meant clinicians could change processes to patient care to ensure they reflected up to date clinical guidance. However, there was no formal system to review the implementation of national guidance. Staff said some changes to guidance which related to General Practice were discussed at meetings, but not all. Clinical audits did review the use of guidance, but audits were only undertaken on some areas of patient care for specific conditions and their outcomes were not always shared amongst staff. For example, an audit of diabetes annual reviews was undertaken but the outcome was not shared with a nurse who undertook diabetic reviews. Therefore changes to clinical guidance may not have been identified, shared with staff or implemented.

There were templates for reviewing or treating specific conditions available to staff. The templates were provided on a computer system and were updated to reflect the most up to date national guidance. This assisted staff in providing up to date and consistent care which reflected national guidance.

Management, monitoring and improving outcomes for people

Patients were complimentary about the quality of care and treatment at the practice. They said doctors and nurses provided good quality care and referrals were made in a timely way. Patient feedback about the repeat prescription service was positive.

The practice undertook an audit due to potential concerns about reviews of patients with a specific condition. The audit identified the extent of the problem and referred to national guidance. There was a plan put in place to address

Are services effective?

(for example, treatment is effective)

the problem immediately. Another audit was undertaken due to prescribing concerns identified through quality monitoring data. The practice identified the source of the problem and put a plan in place to address the issue. The practice took effective steps to monitor, manage and improve outcomes for patients.

An audit on diabetic reviews was undertaken by the practice in response to issues identified through quality monitoring. A nurse we spoke with who undertook diabetic reviews had not been informed of the audit outcome or action plan. The nurse was unaware that there was a potential concern about reviews of diabetic care from quality monitoring. The practice did not always discuss outcomes from quality monitoring and related action plans to ensure consistent improvements were made to patient care by clinicians who worked for the service.

Staffing

Staff told us they received an induction when they began working at the practice. We saw evidence of inductions. One staff member told us they were mentored when they started their role in 2013. The practice manager monitored staff training on safeguarding, emergency medicine, fire safety and information governance to ensure staff awareness on these areas of expertise was current. We saw a training log recorded what training staff received. Staff told us they received appraisals which were supportive. One staff member told us their appraisal led to them receiving specific training. Staff were able to provide effective care because they received the training and support they needed.

The practice had designated staff to fulfil specific roles. For example the nursing team delegated certain clinics and patient care to different nursing staff including a healthcare assistant who was training in taking blood and undertaking certain medical reviews of patients. This enabled the practice to organise patient care effectively and ensure care was delivered by skilled staff.

Working with other services

There were minuted multi-disciplinary meetings with GPs and external professionals such as social workers. Minutes from the meetings noted reviews of individual patients and action for each of the services involved to ensure their needs were being met. The practice promoted external services such as carer support services for patients. However, other services which may have been useful to patients, such as mental health or drug support services, were not visible when we looked in reception on the day of our inspection. Two GP partners informed us there was an array of leaflet information on mental health, drug and alcohol and other services available in a leaflet stand. Some of the information was removed on the day of our visit due to information the practice displayed about the inspection. This may be useful for patients who have concerns they do not want to discuss with their GP or patients who require additional support from another service.

Health, promotion and prevention

We saw the practice provided health and lifestyle information in reception. There was information for carers and patients with medical conditions such as arthritis and dementia. New patients were asked to attend a health check with a nurse when they registered. A nurse told us a basic health check was undertaken during the check-ups and if there were any concerns the patient would be referred to a GP. A smoking cessation service was provided.

The practice Patient Participation Group (PPG) circulated a newsletter called 'The Voice', which had a circulation of 400 patients. This included health and lifestyle information for patients. Clinical staff were able to promote specific health issues or services through the newsletter.

Are services caring?

Summary of findings

The practice was caring. Patients were treated with respect, dignity and courtesy by staff. Their privacy and confidentiality was respected. Staff provided choice and involved patients in decisions about their care and treatment.

Our findings

Respect, dignity, compassion and empathy

Patients told us staff were considerate, respectful and courteous. They told us receptionists were responsive to patients who needed assistance accessing the premises. The practice patient survey from 2014 indicated patients were satisfied with the way they were treated by staff. We saw clinical staff closed doors when consulting with or treating patients. We observed reception staff were kind and caring when speaking with patients. We sent comment cards to the service before our inspection so that patients could provide feedback about the practice. Eight comment cards back were filled in by patients who reported that the staff were considerate and kind.

Involvement in decisions and consent

Patients told us they were involved in decisions about their care and treatment. They said clinical staff gave them the time they needed during consultations and listened to their concerns. The practice used a 'choose and book' system to assist patients making choices with any referrals to external services.

Staff told us they had access to guidance on the principles of the Mental Capacity Act (2005). This would allow clinicians to ensure they knew what action to take if patients lacked the capacity to make decision and ensure any clinical decisions were in patients' best interests if they did lack capacity. This supported staff in protecting patients' rights when assisting them to make a decision about their care or treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. We found staff assisted patients with limited mobility and adjustments were made to the premises to improve access. The practice was considering what action could be taken to improve physical access for patients. The appointment system caused problems for some patients to access appointments on the same day. Although staff were aware of the ethnic diversity in the area the service had not assessed what measures could improve access for patients from specific ethnic minorities or cultures who may require additional support. There was a thorough process for dealing with and responding to complaints from patients.

Our findings

Responding to and meeting people's needs

The building was a converted house with the reception on the first floor. We saw an external stairway led to the reception area. There was access to the ground floor and a stair lift fitted to an internal stair case providing access to first floor where treatment and consultation rooms were located. The entrance to the ground floor was a wide doorway that was accessible for wheelchairs. Patients said staff were responsive to those who needed assistance to get to the first floor. However, patients who required help could not access the premises independently. Patients who could not use the external staircase relied on the stair lift to access any appointments as no consultation rooms were located on the ground floor. In the event of a fire any patients who required the stair lift to exit the premises would be delayed in exiting the building. There was a risk that a loss of power would mean the stair lift would not be working in an emergency. The practice did not have a risk assessment for fire. There was no assessment of the risks associated with evacuating patients with mobility problems. The practice manager told us they had booked a fire risk assessment for the building by an external organisation. In the event the stair lift broke down the practice would not be accessible for the period of time it took for an engineer to fix the stair lift. This meant patients who relied on the stairlift would not be able to access the practice during the time it took for to repair the stairlift if it stopped working during surgery. Parents who attended with buggies or prams needed to carry young children up the external staircase to access the practice. Prams or buggies would need to be left outside the practice or carried upstairs. The premises did not have an appropriate design and layout to ensure the building was accessible and safe for all patients.

We looked at the practice's 2014 patient survey and saw 27 per cent of patients reported getting through on the phone quickly was difficult. The practice had extended appointment times to enable patients who find it difficult to attend appointments during normal working hours to attend at times that suit them. This was in response to patient feedback. Patients we spoke with and feedback on comment cards filled in by patients before the inspection indicated there was a problem getting through to receptionists and making appointments for the same day. One patient told us they had tried to make an appointment

Are services responsive to people's needs?

(for example, to feedback?)

for their child on three consecutive days but was told on the first two there were none available. We discussed this with the practice manager and a GP partner. The staff we spoke with were not aware of the extent of the problem we identified and therefore did not have a plan improve access to appointments for patients. There was a risk patients were not able to access appointments when they needed them.

Access to the service

The practice manager told us there was limited capacity for clinicians to work due to the size of the building. This made it difficult for the practice to provide more appointment slots to improve accessibility. Staff told us the practice had applied for funding to relocate due to concerns with the accessibility and capacity of the premises. They told us there was currently no funding available with the local NHS to support a move of location. The practice had undertaken a robust analysis of how to improve accessibility at their current location and were considering options. The leadership within the service were working towards improving access to the location.

There was a translation service available for staff to use if patients could not speak English. However, this service was not advertised in the reception area or under the services advertised on the website. The practice did not use a telephone translation service which meant that patients or staff would need to request a translator in advance if one was needed.

Staff were aware of and responded to patients who required support due to restricted mobility. A receptionist told us they considered patient's different needs when assisting them. For example, they said they communicated clearly with patients who had limited hearing to ensure they understood what they said. Patients told us they were supported in using the service by all staff. Different members of staff provided different accounts of the ethnic diversity of the patient population when we asked them. Staff understanding of the local population demographic was based on experience with patients. The practice did not have a breakdown of patient demographics from population data (such as census data) and what support needs the local population might have as a result.

Concerns and complaints

The practice was responsive to concerns and complaints. We looked at a complaints log and saw all complaints were acknowledged, investigated and responded to. We saw from meeting minutes that complaints were discussed by staff as part of investigations where necessary. We saw responses to patients were polite, informative and recognised where mistakes had been made. The practice used a third party organisation who specialised in patient complaints to assist the practice in making a response. Where similar complaints were made we found that staff identified themes and took action to improve the service. Patient concerns were considered and responded to professionally to ensure issues were addressed and where possible improvements to the service were made.

Are services well-led?

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

Summary of findings

The service was well led. The service had an open culture which encouraged staff and patient feedback. We found feedback provided by staff and patients was acted on. There were meetings for all staff to communicate with each other. However, we found some key information was not provided to staff to ensure improvements to the service were made. The practice identified, responded to and managed risks to safety and quality effectively.

Our findings

Leadership and culture

Staff we spoke with told us there was an open door culture with senior members of staff within the practice. They told us the practice manager was approachable and responded to staff feedback. We saw from patient complaints that concerns were responded to in a responsive and pro-active way. A representative from the Patient Participation Group (PPG) told us that the practice manager was supportive of the group and responsive to their feedback. The leadership at the service ensured learning and changes to the service were implemented effectively, to ensure staff knew their responsibilities and the service improved over time.

Governance arrangements

The practice had policies and procedures for staff to follow. We saw these were located in places where staff could access them. For example, the business continuity plan was located in the practice manager's office on a board. Staff told us they knew where to access policies on safeguarding, whistleblowing and other policies. This enabled staff to follow policies and processes in the day to day running of the practice.

Systems to monitor and improve quality and improvement

The practice used the Quality Outcome Framework (QOF) to assess its performance against key indicators of care in General Practice such as clinical outcomes for patients. The QOF is a voluntary assessment tool which is used to allocate funding to GP services based on their local population and performance. We saw evidence which showed the practice responded to areas where performance on clinical outcomes could be improved. The practice undertook audits and identified actions as a result of audit findings. However, there was no formal system to ensure patient care was consistent and always reflected up to date clinical guidance.

Staff engagement and involvement

The practice held regular meetings. All staff were involved regularly in meetings with either practice partners or the practice manager. We looked at minutes from meetings between clinical staff and reception and administration staff. Discussion on policies and processes, new guidance and reviews and actions of complaints and significant events were minuted. The practice facilitated staff to communicate with each other and with management.

Are services well-led?

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

Patient experience and involvement

Patient feedback was sought through the practices annual survey, by the PPG and was considered when complaints were received. The practice manager told us patient feedback on the appointment system in 2013 was acted on by the practice by extending appointment times. This improved access to appointments for patients who could not attend during normal working hours. One patient told us the extended hours appointments were very useful to them. In the 2014 patient survey the practice survey there were concerns raised with getting through on the phone to book appointments. This was consistent with feedback we received from patients we spoke with and on comment cards we left at reception. Patients were also concerned about difficulty in booking appointments on the same day. When we fed this back to a GP partner and the practice manager they were unaware that there were consistent concerns among patients regarding access to appointments.

Learning and improvement

Staff discussed significant events and complaints in meetings to identify any action to improve quality and safety. Significant events were discussed with relevant staff at the time of the event and periodic reviews of significant events took place every three months. We saw from meeting minutes there were clear actions to improve and learn from complaints and significant events where possible. This ensured improvements to the quality and safety of the service were made following incidents.

Identification and management of risk

The practice was pro-active in identifying and responding to risks related to the premises, equipment and cleanliness. A potential risk related to hygiene and infection control regarding patient samples was identified and action taken by the practice manager. The service did not use an audit tool for hygiene and infection control. Therefore some risks related to infection control may not have been identified.

The service provided staff with fire safety training. There was no fire risk assessment for the building. The practice manager told us they had booked a fire risk assessment for the premises from the same organisation that provided the fire safety training to staff.

There was a control of substances hazardous to health (COSHH) risk assessment available for all the chemicals used by the cleaners. The assessment was readily available for staff to refer to if required. This meant the risk when using hazardous chemicals was reduced.

Information on the procedure following a sharps injury (such as a needle stick injury) was available on consultation and treatment room walls. This meant staff who were at risk of such an injury would have information immediately and could take appropriate action.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Health promotion was provided to older patients through specific immunisations, information and advertising of external services. Accessibility to the surgery could be difficult for older patients with mobility issues but staff were supportive and responsive to patients who required assistance.

Our findings

Staff were provided with training in safeguarding vulnerable adults, such as older patients who may be vulnerable due to their health, mobility or circumstances. Staff knew how to respond to a suspicion of abuse. The practice offered patients over 65 years of age an annual influenza vaccine. We saw support groups and information for patients with arthritis or dementia was advertised in the waiting area. The practice promoted external services such as carer support services for patients. The practice Patient Participation Group (PPG) circulated a newsletter called 'The Voice', which had a circulation of 400 patients. This included health and lifestyle information for patients. Clinical staff were able to promote specific health issues or services through the newsletter.

Access to the practice was difficult for patients with mobility problems. Patients and receptionists told us staff were supportive in assisting patients to use alternative doors. However, there was a risk that the premises would not be easily evacuated by patients with restricted mobility in the event of an emergency.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The service provided periodic reviews for patients with long term medical conditions. Some annual checks for patients were not completed but the practice had taken action to remedy this concern.

Our findings

Patient annual reviews had been undertaken in a timely way to ensure long term conditions were monitored and managed in line with best practice and national guidance. Health promotion advice and information relating to specific health conditions was available in the waiting room of the practice. This included advice on arthritis and dementia. There was also information on local support groups for patients with diabetes. Flu vaccinations were offered to patients with long term conditions because flu can cause complications or serious illness for patients who suffer from conditions such as diabetes.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Appointments for pre-natal and antenatal check-ups were available. We found a concern about the responsiveness of the practice in booking an appointment for an unwell child.

Our findings

A mother with a young child told us they had tried to make an appointment for three consecutive weekdays. They said the reception staff told them there were no appointments available on the first two days. They told us they were given an emergency appointment on the third day which had not been offered before. The parent told us there was no immediate risk to the child but they were upset that the practice had not responded in a timely way to a child that was unwell. We reported this to the practice manager and a GP partner who said they would review the access to appointments.

Check-ups and appointments for immunisations were offered to expecting mothers and those with babies and young children. There was no information on sexual health available in reception which may relevant to young patients up to 19 years old.

Patients told us staff communicated well and were considerate. Children were supported by caring staff.

The practice was not easily accessible for parents with young children, particularly those with buggies or prams.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Access to appointments for patients had been improved due to feedback from the annual survey. However, a lack of access to the telephone system meant patients who worked may find it difficult to book an appointment. We were told that it was difficult to get same day appointments.

Our findings

The practice provided appointments from 6.30 am on Wednesdays and 7.15 am on Fridays for patients who found it difficult to attend during normal working hours. This improved access for patients who work. Most patients we spoke with told us it was difficult to speak to a receptionist when appointments were released in the mornings. This would make it difficult for patients who needed to call the practice, due to work commitments, to contact the surgery. Flu vaccinations were offered to patients over 65. This could be relevant to patients who had recently retired.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Staff were provided with safeguarding training and were aware of how to identify potential abuse and report it. The service did not provide a translation service for patients who did not speak English.

Our findings

Staff we spoke with were aware of indicators of potential abuse for both adults and children and knew who the practice safeguarding lead was. The practice made a safeguarding referral to the local social care team regarding a child within the last year due to concerns identified by staff.

Receptionists told us they said they communicated clearly with patients who had limited hearing to ensure they understood important information. There was no readily available language translation service for staff to access if patients needed a translator. This meant patients would need to wait for an external translator to be booked if they needed to speak with a GP but could not communicate directly. Patients with physical disabilities or those who had restricted mobility could not access the premises independently or safely.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Information which may have been useful to patients with mental health problems was not available in the waiting area or on the practice website.

Our findings

Services which may have been useful to patients, such as mental health services, were not displayed on the practice website or in the waiting area.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15(1)(a) The provider did not ensure service users were protected from the risks associated with unsafe or unsuitable premises because the design and layout of the premises were not suitable.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15(1)(a) The provider did not ensure service users were protected from the risks associated with unsafe or unsuitable premises because the design and layout of the premises were not suitable.

Regulated activity	Regulation
Surgical procedures	Regulation 15(1)(a) The provider did not ensure service users were protected from the risks associated with unsafe or unsuitable premises because the design and layout of the premises were not suitable.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15(1)(a) The provider did not ensure service users were protected from the risks associated with unsafe or unsuitable premises because the design and layout of the premises were not suitable.