Drs K Conod, R Jarrams & S Caddy

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Drs K Conod, R Jarrams & S Caddy is also known as The Limes Medical Centre. Overall the practice is rated as good.

Specifically we found the practice requires improvement for safe services but was good for providing effective, responsive, caring and well led services. The practice was found to be good for the services it provided to all population groups.

Our key findings were as follows:

- Emergency medicines and medical equipment were not managed safely and not all staff were aware of their roles in the event of a medical emergency.
- The practice had effective procedures in place that ensure care and treatment was delivered in line with appropriate standards.
- Patients were treated with dignity and respect. Patients spoke very positively of their experiences and of the care and treatment provided by staff.
- The practice was responsive to patients' needs and provided services that reflected the needs of the patients.
- We found that the service was well led overall. The practice engaged with the patient population and made changes to service where appropriate as a result of their feedback.

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

The provider must:

- Ensure medication management systems are robust.
- Ensure emergency medical equipment is in date and checked regularly to ensure it is safe and in working order.

In addition the provider should:

- Ensure DBS checks or appropriate risk assessments are carried out for staff who assume the role of a chaperone.

Summary of findings

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. Some systems in place were not robust and did not ensure patients received a safe service. We did not see any evidence to demonstrate that checks had been undertaken on emergency medical equipment and we saw that some emergency medical equipment was out of date. We also saw evidence to demonstrate that some of the medicines and vaccines were not stored appropriately. Systems were in place to learn from complaints and clinical incidents. Administration staff did not report incidents. There were plans in place to ensure the practice could still operate in the event of a major incident. However, not all staff we spoke with were aware of the plans and in the event of a major incident they may not be aware of the actions to take. Records we looked at showed that clinical staff had a criminal records check through the Disclosure and Barring Service (DBS). However, we found an occasion when a member of staff who had acted as a chaperone but not been subject to a DBS check or appropriate risk assessment.

Are services effective?

Good

The practice is rated as good for providing effective services. There was evidence of clinical audits undertaken to improve outcomes for patients. Care and treatment was delivered in line with best practice guidance. The practice had joint working arrangements with other health care professionals and services to ensure care and treatment was co-ordinated. A system was in place to check the professional registration for all clinical staff. Opportunities were available for staff to undertake professional development. Staff appraisal had taken place which set targets and these targets were reviewed when appropriate.

Are services caring?

Good

The practice is rated as good for providing caring services. People's privacy, dignity and right to confidentiality were maintained. Translation services were available to people whose first language was not English. Patients we spoke with and feedback from comments cards we received reflected the positive experiences patients received from the service. Patients felt that staff treated them with dignity and respect and spoke to them in a helpful and polite manner. The practice had conducted a patient survey and had taken action where appropriate. We looked at the most recent national GP patient survey which revealed that 92% of respondents

Summary of findings

said the last GP they saw or spoke to was good at treating them with care and concern. This was better than the local average. The practice was proactive in providing end of life care. Families were supported following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was accessible to patients with limited mobility, or whose first language was not English. The practice had systems in place that ensured patients with urgent care needs were seen with minimal delay. There were a number of ways in which patients could make an appointment at the practice, including online, by telephone or in person. Home visits were available for patients who were not able to attend the practice in person and telephone consultations were also offered where appropriate. We saw that complaints had been received and responded to appropriately by the practice. The practice had a patient participation group (PPG) to gather patient opinion regarding the service offered. The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, a member of the group told us that they were consulted on the design of the patient survey and their feedback was used to create a condensed survey that patients would be willing to complete.

Are services well-led?

Good

The practice is rated as good for being well-led. The GPs took a lead for different areas of the practice such as safeguarding. The practice had started 'business' meetings between a GP partner and the practice manager as a way of ensuring all staff received information relevant to their role. There was evidence of improvements made as a result of audits and feedback from patients. Patients' views on the service were listened to and were used to improve services. The practice had a patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice was accessible for patients who had limited mobility.. All the consultation rooms were on the ground floor of the practice. If patients were unable to attend the practice because they were housebound they could be seen at home. Telephone consultations were also available. We received good feedback from managers of local care home regarding the service offered by the practice. They told us that the GPs undertook home visits on request. Health checks and medication reviews took place and repeat prescriptions were easily accessible. The practice was taking part in the enhanced service aimed at reducing avoidable unplanned emergency admissions to hospitals for vulnerable and older people. There were arrangements in place to ensure continuity of care for those patients who needed end-of-life care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had arrangements to care for people with long term health conditions, for example those with chronic obstructive pulmonary disease (COPD) and diabetes. There was a clinical lead to ensure patients were called for check-ups for conditions such as diabetes. The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to hospital. The focus of this enhanced service was to target specific patient groups such as patients with long term conditions and develop plans for coordinated care. Patients who were on long term medication, as a result of their condition, received regular reviews to assess their progress and ensure their medications remained relevant to their health needs. Regular review meetings were held with a multidisciplinary team to discuss each patient. There were arrangements to share information with out of hours services when the practice was closed to ensure people received co-ordinated care and treatment which met their needs.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had arrangements in place to ensure the needs of mothers, babies, children and young people were met. For example the practice nurse undertook childhood vaccination programmes, and chlamydia testing. Antenatal care was provided by both midwife and the GPs on a shared-care basis and postnatal examinations are done by the GP. The practice had stopped running

Summary of findings

baby clinics at set times because working patients could not always attend the clinic times. As a result parents were able to book appointments for a check-up of their babies at a time that suited them. Health Visitors were available for general advice on sleeping and feeding in respect of new born babies. Young adults had access to preventative sexual health services provided by the practice including screening for Chlamydia (a sexually transmitted disease).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice had appropriate arrangements in place to ensure the needs of working age patients and those recently retired were met. Access to the service could be made by telephone, in person or online; via the internet. Consultations with a GP were available from 8:30am Monday to Friday and patients were able to see a nurse from Monday to Friday 7:30am to 11:30am. There was a recall system in place for cervical screening. This procedure was carried out by the practice nurse. Information leaflets and posters were available in the patient waiting area and on the practice website to support and signpost people to support groups and organisations. This included information about self-management of minor illnesses. Opportunistic health checks and advice was offered (for example blood pressure checks and advice on family planning). Holiday vaccination advice was available through consultation with a practice nurse.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. People were able to telephone the practice and speak with a doctor for a telephone consultation. This allowed timely access to vulnerable patients and supported decisions relating to hospital admissions, in order to reduce avoidable hospital admissions or A&E attendances. The practice had identified vulnerable people and completed care plans to help ensure they received the most appropriate care. The practice carried pout regular NHS Health Checks as well as alcohol screening which helped patients to receive the appropriate advice, support and treatment. Information leaflets and posters were available in the patient in the practice and on the practice website to support and signpost people to support groups and organisations. The practice offered sexual health and substance misuse support, advice, and referral for patients. Staff members we spoke with were unsure what they would do if a patient without a fixed address needed to see a GP. The practice did not have a clear policy in place if such a situation was to occur.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Dementia screening for all patients over 65 was available at the practice. This enabled patients to receive appropriate treatment and support if they were developing symptoms of dementia. The practice offered depot injections. These are longer acting injected medicines used for some patients experiencing mental ill health. Patients with mental health problems had the choice of having this injection at their GP surgery rather than an outpatient clinic or mental health centre if this was more convenient or more preferable to them. A community psychiatric nurse (CPN) was based at the practice two afternoons a week. There was a three week waiting time to see the CPN who was funded by the Clinical Commissioning Group (CCG).

Summary of findings

What people who use the service say

We spoke with five patients who used the service and received 26 completed comment cards. Most of the patients told us they were very happy with the standards of care received at the practice. Similarly, all of the comment cards were positive about the clinical staff at the practice. People commented that the GPs were caring, understanding and helpful. All of the patients said the GPs and nurses were knowledgeable about their health needs. We spoke with managers at five care homes where some patients registered at the practice lived. We were told that patients were able to get an appointment when required and home visits were available on the day requested if they called in the morning. We spoke with a member of the practice's patient participation group (PPG). The patient participation group is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. The PPG met every six weeks and the minutes from each meeting were recorded. We were told that the practice was receptive to feedback from the PPG. PPG members we spoke with before our inspection told us that patients were happy with the service provided.

A patient survey was undertaken by the practice in 2013 -14 and the majority of patients were satisfied with the care they had experienced. We saw an analysis of the survey with follow up actions so that service could be further improved. They included better explanation for the criteria of emergency appointments to be displayed to avoid any confusion and appointment system to be explained in more detail.

Areas for improvement

Action the service MUST take to improve

- Ensure medication management systems are robust.
- Ensure emergency medical equipment is in date and checked regularly to ensure it is safe and in working order.

Action the service SHOULD take to improve

- Ensure DBS checks or appropriate risk assessments are carried out for staff who assume the role of a chaperone.

Drs K Conod, R Jarrams & S Caddy

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor, a second CQC inspector and a specialist advisor with practice management experience.

Background to Drs K Conod, R Jarrams & S Caddy

Drs K Conod, R Jarrams & S Caddy, also known as The Limes Medical Centre, is part of Walsall Clinical Commissioning Group (CCG) area which has 63 practices.

There were five GPs (two male and three female) working at the practice at the time of our inspection. In addition, there is a practice manager, two practice nurses and a team of administrative staff.

There are approximately 6900 patients registered with the practice. The practice has a higher proportion patients aged over 65 compared to the England average. It also has a lower proportion of patients under the age of 40 compared to the national average.

The practice has a General Medical Service contract (GMS) with NHS England. The practice also provides some enhanced services such as minor surgery. An enhanced service is a service that is provided above the standard GMS contract.

The practice opening times are from 7.30am until 6 pm Monday to Thursday and 7.30am until 12 noon Friday.

Cover for primary healthcare on Friday afternoon was available to patients and details of how to access this were available on the practice answer phone. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service, Birmingham and District General Practitioner Emergency Room, contracted by the CCG.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 7 October 2014, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out an announced visit on 07 October 2014 and carried out a comprehensive inspection.

Before our inspection visit we spoke with a member of the Patient Participation Group (PPG) and managers of five local care homes. The PPG is a group of patients registered with the surgery who have an interest in the services provided. The aim of the PPG is to represent patients' views and work in partnership with the surgery to improve the service.

Detailed findings

During our visit we spoke with five patients whilst they were waiting to attend appointments. We spoke with a range of staff, including a nurse, three GPs, administration staff, and the practice manager. We looked at the practice's policies and other general documents.

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

There was a system in place for reporting and investigating incidents. The practice did not routinely share learning from all incidents. With the exception of the GPs, most practice staff we spoke with were unaware of the necessity of reporting incidents.

We saw some evidence of incidents that were reported by GPs and where the learning was shared in clinical meetings which were attended by clinical staff. There was no evidence that this was being shared with administration staff when appropriate.

There was a system for recording accidents in the accident book however learning from accidents was not shared with the practice staff..

Learning and improvement from safety incidents

There was evidence that the practice had an open approach to investigating clinical incidents which were reported by GPs. We looked at the records of five clinical incidents which had been investigated. The minutes of clinical meetings we reviewed demonstrated that any learning identified was shared and actioned to improve outcomes for patients. However, this was limited to clinical staff only.

Reliable safety systems and processes including safeguarding

The practice had a system to identify vulnerable adults and children. There were alerts on the patients' records that informed GPs and nurses where there were any safeguarding concerns.

Staff we spoke with demonstrated their understanding of the term safeguarding. They were aware of the action they should take if they suspected anyone was at risk of harm. Staff told us that there were policies and procedures in place to support staff to report safeguarding concerns to the named responsible GP within the practice and to the local safeguarding team. However staff we asked told us that they were unsure of the content of the policy as they had not looked at the policy for a while. Some staff members were unsure where the policy was kept. Staff members did not know if the policy contained contact details that they could consult for further advice or referral.

Staff members we spoke with confirmed that they had attended safeguarding training (both children and adults) approximately 18 months previously. The practice manager told us that they were booked to attend the next available date for refresher training .

We saw evidence that all clinical staff had appropriate levels of training in children and adult safeguarding for their role and responsibility.

We saw posters displayed in the practice informing patients that they could have a chaperone with them during their consultations. The practice manager told us that only clinical staff acted as chaperones. However, one administration staff we spoke with told us that they had acted as a chaperone on one occasion but had not had the appropriate guidance. In the absence of training the practice were unable to demonstrate that all staff had the necessary knowledge and understanding to undertake this role.

Medicines Management

A system for disseminating alerts about medications was in place. Alerts were forwarded via email to all GPs in the practice with details of the action that was required. This was being audited on site by the prescribing pharmacist from the Clinical Commissioning Group (CCG).

Vaccines and emergency medicines were stored in the practice. We saw evidence that arrangements were in place to check emergency medication regularly to ensure they were still in date.

We saw there were three fridges in the practice, two pharmaceutical and a domestic fridge. We saw that one of the pharmaceutical fridges was used to store medicines and vaccines and another to keep patient samples such as blood. We saw that the domestic fridge had vaccines stored inside. On the day of our inspection the practice was running a flu clinic and staff told us that the domestic fridge was used as an overflow when the practice ordered extra vaccines for the flu clinic. We discussed with the practice manager that this was not appropriate to keep vaccines in a domestic fridge.

We saw that the temperatures in two pharmaceutical fridges were being monitored to ensure medicines, vaccines and patient samples were within the correct temperature ranges. The temperature on the domestic fridge was not being monitored and that the digital

temperature reader on the fridge was not set appropriately and consequently gave readings that were outside of the recommended temperature range. We saw that no action had been taken and pointed this out to staff so that they could respond appropriately. A practice nurse measured the temperature of the fridge using an alternative reader and confirmed that the temperature was within the recommended range and that the digital temperature reader had been set inaccurately. The practice nurse transferred the vaccine from the fridge into the main pharmaceutical fridge. However, we asked the practice to seek guidance before they were moved and used. The practice nurse confirmed that they had sought guidance on the appropriateness and effectiveness of the vaccines and that they had received assurances that they were okay for them to use.

After our inspection, the practice informed us that they had taken action so that processes and procedures for monitoring medicines and equipment were more robust.

Cleanliness & Infection Control

Before our visit we were informed by NHS England that they had undertaken contracts monitoring visit had found the practice to be in breach of infection control guidance, mainly around clinical rooms. NHS England holds the contracts for GPs and NHS dentists. As a result the practice was asked not to undertake certain clinical procedures. We spoke to the provider about this and they told us that the problems were caused by the age of the building. They were responding to the issues raised by the contracts team. We saw the action plan they had been given and they were working through the action plan and making changes where appropriate. The practice had plans to move from its current location to a more suitable site. Plans had been on-going for a number of years but negotiations were still on-going with relevant authorities.

Patients told us that they found the practice to be clean. We found the practice was generally visibly clean and tidy. However, we saw an area in one of the nurse's room to be visibly unclean. This included the emergency oxygen cylinder which appeared unclean. Furthermore, we saw a hand rail in the disabled toilet to be rusty.

Environmental cleaning of the whole building was undertaken by a cleaner employed by the practice. We spoke with a cleaner who told us that there was a cleaning schedule for them to ensure all areas of the practice was being cleaned. However, there was no evidence to show that the quality of the cleaning was being monitored to ensure the practice was being cleaned to an appropriate standard.

Equipment

Emergency equipment including a defibrillator and oxygen were available for use in the event of a medical emergency. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia (a very rapid erratic beating of the heart) present. However, we saw that some medical equipment such as oxygen masks and tubing had passed their expiry date and had not been changed. We saw that there were no checks in place to ensure the oxygen and defibrillator was in good working order.

We saw that the practice had a contract with an external company to ensure all fire extinguishers were being maintained. However, we saw that some fire extinguishers were overdue their scheduled annual maintenance check.

We saw all equipment had been tested and that the provider had systems in place for the testing of portable electric appliances (PAT testing) on an annual basis. There were arrangements to ensure routine servicing and calibration of equipment such as blood pressure cuffs and weighing scales.

Staffing & Recruitment

We saw evidence that an appropriate recruitment policy was followed to ensure that the recruitment process was safe. This included seeking references from previous employers and checking appropriate skills and qualifications. This allowed the practice to employ only suitable and appropriately qualified staff.

We looked at the recruitment records for three members of staff and found that a Disclosure and Barring Service (DBS) checks had been completed for clinical staff only. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. DBS checks for administration staff may not be required if a risk assessments is completed covering the scope of their role; this would include the requirement to

act as a chaperone. The practice manager confirmed that there were no risk assessments in place. They confirmed that they would make arrangements to ensure that appropriate risk assessments were carried out.

We saw evidence that the practice had made necessary checks in their recruitment of the most recently employed GP to ensure they were suitable to carry out the duties required in their role. This included DBS checks as well as General Medical Council (GMC) checks. Doctors must be registered with the GMC to practice medicine in the UK.

All staff had their clinical qualifications recorded and checked on an annual basis or on renewal of their professional registration. There was evidence that staff appraisals were carried out annually and staff we spoke with felt supported in their role.

Monitoring Safety & Responding to Risk

We found that some emergency equipment was out of date and the medical oxygen and defibrillator was not being checked regularly to ensure they were in working order.

We saw that staff needed to go on refresher training for cardio-pulmonary resuscitation (CPR) and the practice manager showed us a list of staff that had been booked to attend. Some of the staff we spoke with were unaware of their responsibilities in the event of a medical emergency and did not know where the emergency medical equipment was located. We found all administration staff were due to attend refresher training for safeguarding children and vulnerable adults

The practice had an annual contract for the maintenance of fire-fighting equipment. However, we saw that some fire extinguishers were due maintenance and there was no evidence to demonstrate that they were serviced.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan to help it deal with emergencies that might interrupt the smooth running of the service such as power cuts and adverse weather conditions. Most of the staff members who we spoke with were unaware of the business continuity plan and could be unprepared in the event of a major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. There was a systematic approach to identifying relevant legislation, latest best practice and evidence-based guidelines and standards. Clinical staff had access to policies, procedures and clinical guidelines via the intranet. We saw minutes of regular clinical meetings to discuss new guidelines and to ensure existing guidance such as National Institute for Health and Care Excellence (NICE) was followed.

The practice aspired to deliver high-quality care and participated in 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 e.g. diabetes and implementing preventative measures. The results are published annually. The practice was a high QOF achiever and had identified area where further focus was required, namely diabetes which it was focusing on this year.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to secondary care. GP practices can opt to provide additional services known as enhanced services that are not part of the normal GP contract. By providing these services, GPs can help to reduce the impact on secondary care and expand the range of services to meet local need and improve convenience and choice for patients. The focus of this enhanced service was to optimise coordinated care for patients with complex conditions. We saw that many patients had been identified and personalised care plans were put in in place. This allowed the practice to assess the needs of their at risk patients in view to developing better management strategies.

Management, monitoring and improving outcomes for people

The practice was a high achiever on the Quality and Outcomes Framework (QOF). The practice had identified patients that had not attended for check-up the previous year and had had called them for check-ups early this year. This allowed the practice to improve outcomes for those hard to reach group of patients.

The Practice had a system in place for completing clinical audit cycles. Examples of clinical audits included prescribing pattern in palliative care. This audit was due for completion in December 2014 and any findings would be implemented after the audit. We saw that an anticoagulation audit was done and a re-audit was due by one of the GPs.

Effective staffing

We saw that the practice had purchased an online training tool. This allowed staff to complete a variety of training courses such as health & safety, manual handling, infection control and risk management. The practice manager told us that they had recently purchased this tool and staff had not completed any of the training due to some staff shortages. The practice manager demonstrated how they would be able to monitor this for better management of staff training needs. We also saw that core training such as safeguarding children and vulnerable adults and CPR was arranged externally.

We saw that new staff received an induction which was fully documented. The induction covered a wide range of topics around the staff member's role and responsibilities as well as covering topics such as privacy and dignity. Staff we spoke with also confirmed that they had undertaken an induction and an induction pack was given to them.

We saw that processes were in place for GP revalidation. Revalidation is a mechanism for doctors to prove their skills are up-to-date and they remain fit to practice medicine. Records we looked at confirmed that clinical staff were registered with their professional bodies.

We saw that annual appraisals had taken place to help develop and support staff. We saw that appraisals were used to identify developmental areas for staff and all of the staff who we spoke with felt supported in their role.

Working with colleagues and other services

We saw evidence of care that was co-ordinated. There was effective communication, information sharing and decision making about patients' care across all of the relevant services involved. We spoke with a GP who was the lead for palliative care. They told us that information was faxed to relevant organisations about patients on the palliative care register and included details of medications they were prescribed. We saw there were quarterly meetings between GPs, district nurses and occasionally social care teams.

Good

Are services effective?

(for example, treatment is effective)

There was a system in place to ensure the out of hours service had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care. Details of any patients attending out of hours services were received and reviewed daily by GPs.

We were aware that the practice worked with local residential care homes. We spoke with five of the care home managers and they told us that, when appropriate, patients received visits from the GPs when requested.

We saw minutes of meetings where there was pro-active work taking place in areas of prescribing. There were regular meetings with a prescribing pharmacist which helped to identify problems and initiate change when possible.

Information Sharing

The practice had an electronic system to receive and send information to other providers such as the out of hours services. Information received was reviewed daily by a GP at the practice so that any management plans could be followed up.

There was a system in place to ensure the out of hours service had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care.

Consent to care and treatment

We saw that the practice had developed shared care plans for many of the patients with long term and complex conditions. The practice involved patients to take part in developing their care plan so that they were involved in the decision making.

The practice offered interpreters to patients that did not speak English so that they could be made aware of their treatment.

Health Promotion & Prevention

Newly registered patients were offered health checks to review and note details of their medical, family and social (occupation and lifestyle) history.

We saw minutes of meetings where the practice had planned to issue letters for health checks to patients over the age of 40. The **Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia.** Patients between the ages of 40 and 74, with certain risk factors are invited once every five years to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and then given support and advice to help them reduce or manage the risk.

The practice offered various screening tests including for sexual health (chlamydia), dementia screening for over 65 year old patients and alcohol dependence. These assessments allowed patients to receive the appropriate treatment or to be referred to other appropriate healthcare professionals.

We observed that information on a range of topics was available in the practice waiting room. This included advice on smoking cessation, weight management, physical activity, health checks, diabetes, and cervical screening.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All of the patients who we spoke with were positive about the attitude and behaviour of staff. We received 26 completed comments cards and they were all positive about staff. Patients described how they were included in their care and treatment decisions.

We observed interactions between staff and patients were polite and respectful. We saw that patients' confidentiality was considered as much as possible by staff. Conversations with patients were discreet so that they could not be overheard. We saw a poster on display in the patient waiting area informing patients that they were able to ask to speak to a member of staff in a private room. We also saw a notice informing patients of the procedure if they felt unfairly treated.

Care planning and involvement in decisions about care and treatment

Before our inspection visit we reviewed the results from the national GP survey. The survey showed positive feedback about patient's' involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the survey showed 78% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were above the local CCG average. The results from the practice's own satisfaction survey showed that most patients responded with either 'good' or 'very good' when asked about involvement in decision making about their care.

Most patients we spoke to on the day of our inspection told us that the GPs involved them in decisions about their care. They also told us that treatment options and results of any tests were explained to them in a way that they understood. Patient's stated that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported with these views.

Patient/carer support to cope emotionally with care and treatment

We discussed bereavement support with the GPs. We saw that there was a system in place for a GP to pick up any bereavement support issues so that the family members could be contacted for further support and signposted to other organisation where appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice website provided information to patients about the clinics and services provided by the practice and other local healthcare services. The website also allowed patients to download a triage form to make urgent appointments as well as informing them of the process for requesting home visits. Arrangements were in place to ensure that patients needing urgent medical attention from a GP were seen with minimal delay.

The practice had arrangements for managing patients with chronic conditions such as asthma, diabetes and heart disease. Patients were invited for regular reviews of their health condition which were carried out by the GPs and trained nurses. We were told that the nurse's appointment slots varied depending on the purpose of the appointment. For example, an appointment for a diabetes check was for 30 minutes. This allowed for patients to be assessed appropriately.

We spoke with the managers of five care homes for older people whose residents were registered at the practice. We were told that doctors from the practice visited the home to see patients when requested. We were told that the doctors met the needs of the patients and patients did not have to wait too long for a visit.

We spoke with a member of the Patient Participation Group (PPG) and received positive feedback. The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. They confirmed that the practice was receptive to the advice from the PPG. For example, they told us that they were consulted on the design of the patient survey and their feedback was used to create a condensed survey that patients would be more willing to complete. We saw minutes from a previous PPG meeting where analysis of the patient survey was given so that the PPG members could discuss the results and prioritise findings.

We saw minutes of meetings where patients with serious or complex needs were discussed at regular clinical meetings. This ensured that all clinical staff involved in their care delivery were up-to-date and knew of any changes to their care needs. We saw evidence that the practice implemented the gold standards framework (GSF) for end of life care with a designated lead GP. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient's needs.

Staff members we spoke with were not aware of what actions to take when a patient without a fixed address needed to see a GP. The practice did not have a clear policy and staff were unsure what they would do. The practice manager confirmed that they had never had to deal with such a situation.

Tackling inequity and promoting equality

Patients were able to make online appointments if they wished. This ensured choice and convenience for working age patients as well as other groups.

The practice offered an interpreting service so consultations could be conducted in a language patient spoke.

We saw that the practice website listed various local services available to patients. These included information on bereavement services, neighbourhood professionals as well as other health services and advice on common medical issues and self-treatment.

The practice undertook telephone triage/ consultation. Patients were phoned by a GP who either dealt with the problem on the phone or agreed with the patient whether and how urgently they needed to be seen. The practice also undertook home visits for patients who were unable to attend the practice.

Access to the service

Daily emergency appointments were available were shared between all clinicians. Home visits were also available for patients that could not attend the surgery.

The building was accessible for patients who required the use of a wheelchair or for parents with prams or pushchairs. All consultations were provided on the ground floor and there was a disabled patients' toilet near the front entrance.

The practice opening times were publicised in the practice and on its website. The practice participated in the extended hours enhanced service offering appointments starting from 7:30am until 6:00pm on Monday to Thursdays with nurses. This enabled better access to working age patients and students. On Fridays, the practice closed at

Good

Are services responsive to people's needs?

(for example, to feedback?)

noon and cover was provided by a separate out-of-hours service. There was an answerphone message giving the telephone number patients should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the surgery and on the practice website.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was on display in the waiting area and was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that the practice had received four complaints since April 2014. We saw that complaints had been responded to in line with the practice's complaints procedure.

We did not see any documented evidence that complaints had been discussed and learning shared with staff to improve service. However, the practice manager and other staff members we spoke with were able to describe changes made as a result of complaints made, so that patients received a better service. For example, the practice had changed the processes for emergency appointments as a result of patient complaints. The practice had also changed baby clinics running at set times as some parents who were working could not make these times. Patients were now able to book appointments for their babies at any time that suited them.

The PPG member we spoke with felt the practice dealt with issues and complaints in an appropriate way. They felt all concerns they brought to the surgery were dealt with appropriately.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We were sent details of the practice statement of purpose before our inspection visit. The statement of purpose detailed the objective of the practice to deliver a holistic service providing best level of care in terms of preventative and management of chronic and acute conditions.

Governance Arrangements

There was a leadership structure with named members of staff in lead roles. For example, the practice manager was responsible for the day to day running of the practice with other staff having designated lead roles for administrative duties. There were also GP leads for safeguarding as well as for palliative care (GSF).

The practice had a number of policies and procedures in place to govern activity. However, staff were not always aware of them to help them in their role and responsibilities. For example, a staff member we spoke with was unaware of the business continuity plan but had described an incident and the actions they took to ensure business continuity when the computer system was down.

Also, some staff members we spoke with were unclear of the responsibilities for monitoring expiry of emergency medicines and equipment as well as procedures for infection prevention and control within the practice. The practice recognised this and had started regular 'business' meetings between one of the GP leads and the practice manager so that any leadership decisions could be better implemented with other staff. The meetings had started recently and the impact had not been fully assessed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff members we spoke with described the culture of the organisation as supportive and open. They also said that they felt they were supported by the management and were happy to raise issues at team meetings.

The practice had a whistle blowing policy to encourage staff to report suspected serious wrong doing and the policy was available to all staff. However, the policy did not contain third party contact details so that staff could if necessary raise any concerns externally. The practice manager agreed to update the policy to ensure this was included.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through annual patient surveys. We looked at the results of the annual patient survey and 68% of patients said that they would recommend the practice to someone new in the area while 17% said they might. Overall the survey results showed that patients were positive about the practice in areas such as opening hours, staff, consultation and management of their long term conditions.

We saw that some actions were identified from the survey. These included displaying more posters for opening hours as some patients weren't familiar. Other actions included the explanation of the appointment system to be displayed and to include criteria of emergency appointments to avoid any confusion.

The practice had an active patient participation group (PPG) which was comprised of 11 patients. The practice recognised that the PPG members were mainly elderly patients and had attempted to recruit additional members. Posters were displayed in the waiting room, members of the PPG attempted to recruit additional members by approaching patients in the waiting room and GPs also attempted to recruit patients from under or non-represented groups during consultations. We spoke with a member of the PPG group who told us that the practice was receptive to their suggestions.

Management lead through learning & improvement

Staff told us that they felt supported in their roles. Staff files looked at showed that new staff had an induction to the practice to help them integrate better into their role. We saw regular appraisals took place which included a personal development plan.

The practice had a system for reporting clinical incidents and the learning was shared with clinical staff through meetings.

One of the GP at the practice was undertaking a two year audit of the surgery appointment system so that improvements to the appointment system could be identified and changes made based on evidence

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found the provider did not have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time. Some emergency medical equipment was not suitable for use and needed replacing. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.