Clanricarde Medical Centre

Quality Report

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Date of inspection visit: 22 May 2014
Date of publication: 03/10/2014

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

Clanricarde Medical Centre is situated at Abbey Court, 7-15 St John's Road, Tunbridge Wells, Kent, TN4 9TF.

The practice is registered to provide the following regulated activities.

- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

We spoke with 14 patients on the day of our inspection. Patients considered their health care needs were met and they were usually able to book an appointment at a time convenient for them. They said that staff respected their privacy and dignity and they were involved in decision making.

Overall the practice was responsive to individual patients needs and provided positive outcomes, but further improvements were needed in some areas, such as telephone access.

There was a system to carry out regular clinical audits, and the results were discussed at clinical meetings. Improvements were made if needed and were monitored so that care and treatment was planned and delivered in line with best practice.

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

There was a clear strategy in place for clinical governance arrangements, but improvements were needed on overall governance of the service provided.

There was an active Patient Participation Group who considered they were listened and responded to when they suggested areas for improvement; even if the improvements could not be made.

Staff were not formally asked for their feedback in a survey, but considered they were able to raise any issues with the practice manager or GPs. Although training for all staff was in place, there was no information on how often training should occur and whether this had been planned for.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were needed as the practice did not have suitable systems and policies in place to fully protect patients from harm.

Patients were safeguarded from harm, but improvements were needed in the polices that underpinned practice. Staff were not consistently familiar with whom to report concerns to if the lead GP was absent. Training had been provided on safeguarding adults and children, but not to all staff, and it was not refreshed annually.

The provider had arrangements in place for reporting and learning from significant events and incidents that occurred in the practice.

There were arrangements to ensure that blank prescription forms were safely managed and stored to provide an audit trail of use. However, staff did not adhere to them consistently.

The practice was visibly clean and tidy and there were systems in place to manage the risk of cross infection. However, these systems were not effectively monitored to ensure that risks to patients were minimised.

The arrangements for recruiting new members of staff did not ensure that all appropriate checks were carried out before an individual started employment at the practice.

The practice had suitable arrangements in place for dealing with emergency situations and any interruption to the service provided.

Equipment used in the practice was serviced and checked regularly to ensure it was safe to use.

All patients we spoke with considered the treatment and care they received was safe and effective.

Are services effective?

The service was effective and patients experienced outcomes to promote quality of life.

There was a clinical audit system in place. These audits were carried out regularly and discussed at clinical meetings. Improvements were made if needed and monitored. This was done to ensure that care and treatment was planned and delivered in line with best practice.

Staff were aware of the importance of working with other services to achieve the best outcomes for patients health.

Summary of findings

Are services caring?

The practice was caring.

Feedback about care and treatment was complimentary and patients considered that they were listened to.

Staff were caring and polite during their interactions with patients. Patients confidentiality was respected and they received appropriate information before consenting for treatment.

Are services responsive to people's needs?

The practice was responsive to individual patient's needs, but further improvements were needed in some areas.

Patients were able to see a GP of their choice for routine appointments and there were arrangements for patients to make urgent consultations.

All the patients we spoke with were happy with access to services, but several raised concerns about telephoning the practice when it first opened in the morning and stated they experienced long delays on the telephone.

Arrangements had recently been made to increase the number of GP appointments as the result of a previous audit of the appointment system.

Patients were able to access care and treatment from other health professionals who worked with the practice to provide appropriate care and treatment.

Concerns and complaints were thoroughly investigated and changes were made if required.

Are services well-led?

The practice requires improvement in its leadership.

Staff we spoke with considered that the practice leadership was open and supportive, but they felt there was not always the time available to carry out their duties effectively. This potentially could have an impact on patient experience.

There was a clear strategy in place for clinical governance arrangements, but improvements were needed on overall governance of the service provided.

There was an active Patient Participation Group (PPG) who considered they were listened and responded to when they suggested areas for improvement, even if the improvements could not be made.

Summary of findings

Staff were not formally asked for their feedback in a survey, but considered they were able to raise any issues with the practice manager or GPs.

Although training for all staff was in place, there was no information on how often training should occur and whether this had been planned for. This did not ensure that all staff were competent to carry out their role.

There were suitable systems to monitor and manage risks to patients and staff, but these were not used consistently, which placed people at risk of harm.

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
There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Home visits could be carried out if needed for patients who requested an appointment.

Appropriate arrangements were in place to provide care to patients at the end of life, and patients wishes were respected.

People with long-term conditions
The practice used nurses to support people with long term conditions. Joint visits with the GP were arranged to review patients to ensure appropriate care was provided to manage their condition.

Patients were able to access a telephone based consultation service to assist in managing their condition.

Mothers, babies, children and young people
There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Suitable arrangements were in place to care for pregnant women both before delivery and when the baby was born. Parents were consulted about treatment options and consider their concerns were listened to and an appointment was made promptly if needed.

Appropriate arrangements were in place for child health checks and support was made available for their parents.

The working-age population and those recently retired
There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

The practice offered a range of appointment times and telephone consultations to suit patients working patterns.

People in vulnerable circumstances who may have poor access to primary care
There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

People experiencing poor mental health
There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Summary of findings

Patients experiencing poor mental health were able to self-refer to other agencies when needed. Patients had access to counselling services and to a community psychiatric nurse if required.	

Summary of findings

What people who use the service say

Patients who used the service told us that it met their health care needs and they were usually treated with dignity and respect. They said they were given sufficient information to make decisions about their treatment and were involved in the decision-making process.

Patients were able to book routine appointments in advance, but raised some concerns about problems with telephoning the surgery first thing in the morning. They told us they had to wait because the telephones were engaged.

Patients considered that the majority of staff had a friendly caring attitude and they felt safe. They also considered that staff listened to their concerns and they had sufficient time during their appointments to discuss their health needs.

We reviewed information from the most recent NHS Choices patient survey carried out in 2013 over a period of nine months. Overall the practice received a score of four stars for service provision, from a total of seven respondents. Positive comments included helpful reception and clinical staff and a pleasant environment. Negative comments were made about some reception staff having a poor attitude and difficulties in making appointments on the telephone.

The practice carried out a patient survey in November 2013, which was coordinated by a member of the Patient Participation Group. Comments about care received were positive and respondents considered they were not hurried when they attended the surgery. However, concerns were raised about lack of appointments and availability of blood tests and the attitude of some receptionists. The practice had implemented an action plan to address these issues, which was on going.

Areas for improvement

Action the service MUST take to improve

- All staff must be trained annually in safeguarding adults and children according to the practice's own policy.
- Recruitment procedure must be effective and a full risk assessment carried out to show why a Disclosure and Barring Service check has been deemed unnecessary.
- All vaccines stored in medicine fridges must be in date

Good practice

- The practice provided a teledermatology service, which means a photograph is taken of a patient's skin condition and then it can be seen as a digital picture by an external expert for analysis. This resulted in treatment being given earlier than if the usual referral route had been taken.
- The practice used telemedicine to assist in managing some long term health conditions via telecare.
- The practice held meetings with seven other GP practices to discuss joint working with out-of-hours providers and the local hospitals. Other areas discussed included audits of readmissions to hospital, mental health provision and medicines optimisation, which related to medicines that were prescribed. We viewed the minutes for one of these meetings and found that attendees included other GPs, practice managers and prescribing advisors. Items discussed included a pilot Roving GP scheme, which if successful would be rolled out across the CCG. Also discussed were re-attendance audits for patients at accident and emergency when they were discharged from hospital. Recommendations included making better use of community services when a patient was discharged from hospital and improving patient education and awareness. These actions would be reviewed at meetings later in the year.
- There was joint agency working in relation to mental health including open access to some mental health services.

Summary of findings

- The practice encouraged self-care and management in partnership with the local pharmacist.

Clanricarde Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and a GP specialist advisor. The team included a practice manager and a GP specialist advisor and an expert by experience. (An expert by experience is a person who has received or is receiving a service or has caring responsibilities for another person receiving a service).

Background to Clanricarde Medical Centre

Clanricarde Medical Centre is a GP practice situated at Abbey Court, 7-15 St John's Road, Tunbridge Wells, Kent, TN4 9TF. The practice serves approximately 10,000 patients. The service is provided to patients who live in the town and some outlying towns and villages and covers a ten mile radius.

Twenty five percent of the population the practice provides a service for are under 20 years of age. Twenty percent of the population are aged 61 years or over. The majority of patients have English as their first language. There is a Polish community situated within Tunbridge Wells and some of these people are registered with Clanricarde Medical Centre.

The practice is open from 8.30am to 6.30pm on Mondays to Thursdays and 8.30am to 6.00pm on Fridays. Extended hours surgeries are held on Tuesday and Thursday from 7.00am to 8.00am and Wednesday evenings from 6.30pm to 7.30pm. The practice is unable to take telephone calls during extended hours surgeries.

Routine appointments can be made via telephone or online and are available up to six weeks in advance. Patients with urgent conditions can be seen on the day. The practice operates a duty GP system in the afternoons. Telephone consultations can be arranged for those who prefer not to attend the surgery. Home visits can be carried out by GPs for those who are not well enough to attend the surgery.

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 reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the practice, including organisations such as the local Healthwatch, NHS England and the local Clinical Commissioning Group. We carried out an announced visit on 22 May 2014. During our visit we spoke with a range of staff including three of the GP partners, the practice manager, nursing staff, secretaries and receptionists. We spoke with 14 patients who used the service and spoke with six members of the Patient Participation Group.

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?

Detailed findings

- 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

Are services safe?

Summary of findings

Improvements were needed as the practice did not have suitable systems and policies in place to fully protect patients from harm.

Patients were safeguarded from harm, but improvements were needed in the polices that underpinned practice. Staff were not consistently familiar with whom to report concerns to if the lead GP was absent. Training had been provided on safeguarding adults and children, but not to all staff, and it was not refreshed annually.

The provider had arrangements in place for reporting and learning from significant events and incidents that occurred in the practice.

There were arrangements to ensure that blank prescription forms were safely managed and stored to provide an audit trail of use. However, staff did not adhere to them consistently.

The practice was visibly clean and tidy and there were systems in place to manage the risk of cross infection. However, these systems were not effectively monitored to ensure that risks to patients were minimised.

The arrangements for recruiting new members of staff did not ensure that all appropriate checks were carried out before an individual started employment at the practice.

The practice had suitable arrangements in place for dealing with emergency situations and any interruption to the service provided.

Equipment used in the practice was serviced and checked regularly to ensure it was safe to use.

All patients we spoke with considered the treatment and care they received was safe and effective.

Our findings

Safe Patient Care

We saw that systems were in place to process urgent referrals to other care/treatment services and to ensure test results were reviewed in a timely manner once they had been received by the practice. There was a duty doctor system in place to check test results and clinical information on a daily basis.

Learning from Incidents

The practice had arrangements in place for reporting significant events and incidents that occurred in the practice. We discussed this process with the practice manager who showed us copies of the records of these. We found that incidents were discussed with the GP partners and other relevant staff shortly after the incident occurred. Learning points and actions were agreed upon and, if needed, a further review was undertaken. For example, in one case, a specimen was not labelled and therefore could not be analysed at the hospital, which meant the patient had to re-attend to have the specimen taken again. Action was taken to ensure this did not occur again. A GP told us such incidents were usually discussed at the end of business meetings.

Safeguarding

We reviewed the practice policies on safeguarding vulnerable children and adults. We found both policies described what constituted abuse and what actions staff should take if they suspected abuse had occurred. The practice had a designated safeguarding lead who was aware of the need to report all concerns to the local authority who retained statutory responsibility for coordinating safeguarding concerns. However, staff we spoke with were not clear that they could, if needed, approach the local safeguarding authority directly with any concerns, for example if the safeguarding lead was not available.

The policy stated that all staff should have safeguarding awareness training at least once a year. The training programme showed that 17 out of 30 members of staff had not received updated safeguarding training since 2012. This meant that staff were not receiving training to ensure they were aware of current guidance.

The policy had been reviewed in February 2014, but had not been updated to reflect current legislation. For

example, the policy referred to Criminal Records Bureau checks and the Primary Care Trust, which are no longer in existence. There was no information in the practice safeguarding or whistleblowing policy of the role of CQC in these areas. This meant that staff were not made aware of current practice and this could result in areas of concern not being identified.

Monitoring Safety & Responding to Risk

The practice had risk assessments in place to ensure the health and safety of patients, visitors and staff. These included risk assessments relating to safe use of equipment and disposal of single-use devices. A comprehensive fire risk assessment had been completed by the management company responsible for the building the practice was situated in. Areas for improvement to be considered included provision of an evacuation chair and renewal of defective seals on some doors.

There were sufficient notices which identified fire exits and where people should assemble in the event of fire. We found the emergency lighting was effective and fire alarms were checked weekly. Fire extinguishers were available, but staff had not been trained to use them. Fire safety training was carried out for all staff in September 2013.

Medicines Management

We looked at arrangements for handling medicines within the practice. We found there was guidance available for staff to refer to when administering vaccinations, inhalers to assist breathing and emergency drugs available, which may be used to treat severe allergic reactions.

We looked at the storage facilities for medicines in the practice. Medicines that required cold storage were kept in the three medication fridges. The temperature was checked daily to ensure they were working effectively and within current health and safety guidelines. Medicines that were stored at room temperature were kept in suitable lockable cupboards.

If errors were made when writing up prescriptions, these were documented on the significant event form and action taken to minimise the risk of reoccurrence.

The practice had arrangements in place to identify and manage risk, but these were not consistently used. For example, we found one of the fridges contained vaccines which had expired. We spoke with the nurse practitioner about stock monitoring. They informed us that there was no clear system in place to check expiry dates on medicines, but said that when they administered vaccines they checked the expiry date with the parent if the vaccine was for a child.

Cleanliness & Infection Control

The practice had policies on infection control that covered areas such as handling blood samples, dealing with spillages and waste management. The policy did not reference The Health and Social Care Act 2008 Code of practice on the prevention and control of infections and related guidance. However, we found that the polices contained all the criteria set out in the Code in sufficient detail.

There was a nominated person responsible for infection control within the practice.

A risk assessment for Legionella (a bacteria often found in water systems which could cause harm to patients), had been carried out in September 2012. It showed that the management company took corrective action to clean, descale and chlorinate water tanks. A recommendation was to flush little-used outlets twice a week. It was not clear whether the practice had done this. Records of sampling for bacteria were satisfactory and there were no risks to patients.

The policy stated that clinical staff should receive annual training on infection control, but the training schedule did not show evidence that this had happened. We spoke with two members of staff who told us they had not received any infection control training. However, a GP who performed minor surgery said this area had been covered in their minor surgery training. This meant that they were competent to carry out procedures safely.

We observed that there were sufficient supplies of liquid soap and hand dryers available by sinks. Hand cleansing gel was also available for use in the practice. Sinks used for hand washing had clear signage to show staff how to wash their hands thoroughly. We noted from a recent audit that no training had been provided in hand hygiene during the past 12 months. Staff were able to describe appropriate hand hygiene practices to minimise risk to patients.

The practice had suitable arrangements to dispose of clinical and general waste and records we looked at confirmed this.

Are services safe?

General cleaning of the practice was carried out by an external contractor. The cleaning plan had been drawn up with the practice and clearly detailed the areas of responsibility for staff working in the practice and those of the company. We noted that the cleaning plan was reviewed in May 2014 to ensure it was effective. Cleaning frequencies for areas such as the reception area, clinic rooms and pieces of equipment were risk assessed to determine how often they should be cleaned to minimise potential harm to patients and staff working in the surgery. The cleaning plan had information on colour coding for cleaning equipment to be used in specific areas of the practice. We found that there were no supplies of blue or green mop buckets and wet, dirty mop heads were being stored in the cleaning cupboard. This meant that there was a potential risk of cross infection and inadequate cleaning.

We saw that the practice looked clean and tidy. Clinical rooms had disposable curtains for privacy, but these were not consistently dated to indicate when they had last been changed. We found a significant amount of dust had accumulated on curtain rails. This posed a risk of infection to patients. Curtain rails should have been dusted effectively as part of the cleaning plan. We looked at the most recent audit carried out by the cleaning company and found that no action was required. It was not clear how this judgement had been made, as instead of numbers denoting risk being recorded, each box had a line in it. The practice had carried out its own infection control audit in May 2014 and had failed to identify shortcomings.

We also found two pots of a skin paste which had been used. This paste is used to treat skin conditions, such as boils and carbuncles, and poses a risk of cross infection when used on more than one patient.

Two of the GPs performed minor surgery at the practice and one nurse performed treatment of warts and verruca's. A separate clinic room was used for these procedures. We saw there were sufficient amounts of equipment for staff to use and appropriate waste disposal facilities. One of the GPs told us that surgical instruments were used once and then disposed of. They also said that between patients, the nurse assisted them to prepare the treatment area for the next patient to make sure it was cleaned effectively.

Staff we spoke with told us there were sufficient supplies of personal protective equipment such as gloves and aprons. They were able to tell us when they would use them. We saw there were sufficient supplies of protective equipment available for staff to use.

Staffing & Recruitment

The practice employed a total of seven GPs, one practice manager, one nurse practitioner, four nurses and one health care assistant. In addition there were six administrators, one IT administrator, two secretary and seven receptionists. All of the administrative and reception roles were job share or part time.

We looked at files for four members of staff. Three of these files were for clinical staff and one was for an administrator. We found that appropriate checks had not been undertaken. For example, one person who had recently been recruited did not have a recent photograph on file; a criminal records check through the Disclosure and Barring Service (DBS) had not been obtained and a risk assessment had not been carried out to indicate that they should be able to work unsupervised, as per the practice policy. Another two files did not have evidence of DBS checks on file.

We found that appropriate checks had been made on permissions to work in the UK and a check had been made on professional qualifications. All but one member of clinical staff who worked in the practice had been offered vaccination against Hepatitis B.

Dealing with Emergencies

The practice had comprehensive policies and procedures in place for dealing with emergency situations, such as bad weather, equipment failure and staff shortage. For example, if a fridge used to store vaccines was not working then they had arrangements with a GP practice nearby to store the vaccines. There was also information on who to contact to obtain advice on using the vaccines if the fridge was not operational for a long period. In addition alternative sites had been identified for potential use if the practice building became unavailable for any reason. Risks to providing services because of power and utility failure had been considered, as had interruption of access to both clinical and paper records.

Equipment

The practice had suitable arrangements in place to ensure equipment was maintained and safe to use. We saw

Are services safe?

records which showed that portable appliance testing had been carried out regularly and there were no actions to take. Other checks to ensure that equipment was safe to use included weekly checks on medicines and the defibrillator for emergency use.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective and patients experienced outcomes to promote quality of life.

There was a clinical audit system in place. These audits were carried out regularly and discussed at clinical meetings. Improvements were made if needed and monitored. This was done to ensure that care and treatment was planned and delivered in line with best practice.

Staff were aware of the importance of working with other services to achieve the best outcomes for patients health.

Our findings

Promoting Best Practice

The practice operated a clinical audit system to continually improve the service and the best possible outcomes for patients. People with long term conditions were able to access a nurse employed by the Clinical Commissioning Group, who worked in coordination with the practice.

Clinical meetings were held regularly to ensure patients care and treatment was in line with current guidance, such as that of the National Institute for Health and Care Excellence (NICE).

GPs told us that they had a 'buddy' system in operation. This meant that when one GP was on holiday another GP monitored their patient list and dealt with any concerns.

Management, monitoring and improving outcomes for people

Patients told us that they were well looked after and received excellent care and treatment. Examples given included routine annual eye checks, referrals to hospitals and clinics for further treatment of surgery and ante and postnatal care.

We saw that the nursing team and the GP worked with other health professionals to provide appropriate care for patients. For example, for patients at the end of life, specific handover forms were used to provide information to out-of-hours providers and provision of anticipatory medicines. These are medicines which are used at the end of life to relieve symptoms, such as pain and sickness.

One of the GPs undertook a teledermatology clinic every week. This involved taking photographs of a patient's skin condition and sending them to a consultant dermatologist (skin doctor) for advice. The GP told us this had been effective and they had used the advice to improve their practice. For example, if the GP considered the patient had a skin condition that would benefit from emollient creams, they could prescribe these before receiving further advice from the dermatology doctor.

Staffing

The practice employed seven GPs, one practice manager, one nurse practitioner, four nurses and one health care assistant to provide care and treatment. Staff were

Are services effective?

(for example, treatment is effective)

supported to remain current in their practice. There was communication between the nurses and doctors, and formal and informal meetings were held to discuss patient care to ensure it was effective.

Working with other services

The practice held meetings with seven other GP practices to discuss joint working with out-of-hours providers and the local hospitals. Other areas covered included audits of readmissions to hospital, mental health provision and medicines optimisation, which related to which medicines were prescribed. We viewed the minutes for one of these meetings and found that attendees included other GPs, practice managers and prescribing advisors. One items discussed was a pilot roving GP scheme, which if successful would be rolled out across the Clinical Commissioning Group. Also discussed were re-attendance audits for patients at Accident and Emergency when they were discharged from hospital.

Recommendations included making better use of community services when a patient was discharged from hospital and improving patient education and awareness. These actions would be reviewed at meetings later in the year.

The GP we spoke with said that patients with mental health needs were able to self-refer to other agencies such as the Crisis Team, if needed, if they considered their condition had worsened. The GP said that good links with the local mental health hospital and mental health nurses made this an effective service. They added that close working relationships with the local pharmacy also enabled patients to receive appropriate advice on less complex health conditions such as hay fever.

The practice also facilitated talks by external clinicians about patient care, such as a forthcoming talk on urology. (Urology is the branch of medicine that focuses on conditions of the male and female urinary tract including kidneys and bladder and male reproductive health).

Health Promotion & Prevention

We looked at a copy of the new registration form which the practice asked patients to complete. We found that patients were asked questions about their lifestyle, such as whether they smoked and how much alcohol they consumed, alongside current health conditions.

There was a separate form for parents of children who were registering at the practice, which included details on child health clinic sessions, breastfeeding support and contact details for the health visitors.

We saw a range of leaflets displayed in the waiting area that related to health promotion. These included information on alcohol and drug use; smoking cessation and dementia care. We noted that this information was only presented in English and other accessible formats were not readily available, such as large print or other languages.

The nurse practitioner and health care assistant we spoke with told us that they were responsible for some health promotion activities. The health care assistant told us that they were learning how to carry out routine health checks for patients. They had been supported to learn practical tasks such as measuring blood pressure to enable them to carry out the checks.

Are services caring?

Summary of findings

The practice was caring.

Feedback about care and treatment was complimentary and patients considered that they were listened to.

Staff were caring and polite during their interactions with patients. Patients confidentiality was respected and they received appropriate information before consenting for treatment.

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 14 patients on the day of our inspection. They all said that the care and treatment they received met their needs, and they were treated with respect. Parents who had made appointments for their young children considered that the practice had listened to their concerns and made sure they saw a GP or nurse as quickly as possible.

All patients we spoke with said that GPs and nursing staff were good and listened to the concerns and they did not feel rushed during their appointment. Most patients considered that reception staff were respectful. We observed the reception area and how staff interacted with patients. We saw that the receptionist on duty in the morning was helpful and pleasant towards patients and reassured patients when they were anxious. However, in the afternoon one receptionist was observed being curt with a patient's query and their manner changed when they saw a member of the CQC team. This was discussed with the practice manager and the registered manager.

We observed a nurse assisting a patient coming out of the consultation room in a caring manner. GPs were seen to address patients by their preferred name when calling them from the waiting room. The GPs allowed time for a patient to walk to the GP consulting room if they had limited mobility.

Patients confidentiality was respected. The practice had recently installed a sound system which could be tuned to a radio station and this was played throughout the waiting areas. This had allowed a degree of privacy at the reception desk. The training programme showed that administration and reception staff and the practice manager had received training on confidentiality and customer service.

We spoke with one GP about end of life care provided by the practice. They told us the practice had established links and met with the palliative care team and local hospice. They said that another GP who worked in the practice also worked at the hospice. The practice had carried out an audit of end of life care and found that the majority of patients who had chosen to die at home had their wishes respected and had done so. This was enabled by the support of the practice and the palliative care team.

Are services caring?

Patients were able to choose to see male or female doctors and chaperones were available if needed. (Chaperones are members of staff of the same gender as a patient, who supports them when they are being examined by a member of staff of the opposite sex.)

Involvement in decisions and consent

All the patients we spoke with told us that they were given sufficient information to make a decision about their treatment. Parents of children said they were consulted about treatment options and involved in decision making.

We spoke with three of the GPs and they said they would ensure that a patient understood what they were consenting to before carrying out treatment. One GP who was responsible for minor surgery said that they prepared consent forms immediately before the treatment and made sure that the patient was aware of the risks and benefits of the procedure before carrying it out.

The practice information leaflet was not readily available to patients, as they were kept under the reception counter. Reception staff told us that patients could ask for them. We asked two receptionists and some patients who said it was not routinely given when new patients registered with the practice. This meant that patients were not always given information about the services the practice provided.

We observed one patient trying to register with the practice. We noted that their English was limited and they were having difficulty completing the registration forms. A receptionist tried to assist, but there was a language barrier, which meant it was difficult to gather relevant information.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to individual patient's needs, but further improvements were needed in some areas.

Patients were able to see a GP of their choice for routine appointments and there were arrangements for patients to make urgent consultations.

All the patients we spoke with were happy with access to services, but several raised concerns about telephoning the practice when it first opened in the morning and stated they experienced long delays on the telephone.

Arrangements had recently been made to increase the number of GP appointments as the result of a previous audit of the appointment system.

Patients were able to access care and treatment from other health professionals who worked with the practice to provide appropriate care and treatment.

Concerns and complaints were thoroughly investigated and changes were made if required.

Our findings

Responding to and meeting people's needs

We spoke with 14 patients on the day of our inspection. They told us they were able to book appointments in advance with the GP of their choice. All patients were satisfied that they could see a GP in an emergency situation, even if it was not their named GP. They all commented that they were always seen in an emergency, even if it meant they had to wait for a while once they were in the practice. The three GPs and practice manager we spoke with told us that they would always see patients with emergencies.

The practice offered extended opening hours for patients who were working or had other responsibilities which meant they were not able to access the practice during normal opening hours. A duty GP system operated in the afternoon to see urgent cases. GPs also undertook telephone consultations for those patients who did not wish or need to attend the surgery. One patient told us that they had had a telephone conversation and they had been advised to see the GP that afternoon. They considered this was an effective way of meeting their needs. This meant that the practice responded to patients needs effectively.

Patients said they were usually referred to other health service such as the hospital or physiotherapy when needed. We heard of an example where a patient was quickly diagnosed with skin cancer as a result of this service and received surgical treatment within a month. As two of the GPs performed routine minor surgery there was also the option for patients to be treated at the practice if they needed a lump to be removed or if they needed a 'punch biopsy' (a 'punch biopsy' involves taking a sample of skin cells to be tested for cancerous growths). This meant that conditions could be diagnosed and patients received beneficial treatment.

The practice used nurses employed by the Clinical Commissioning Group (CCG), to assist in managing some long term health conditions via telecare. For example, the CCG nurse was responsible for providing education and advice to patients with long term respiratory (breathing) conditions, about managing their condition. The nurse also taught patients how to monitor the levels of oxygen in their blood and take their pulse. This information was input onto a database, along with other information relevant to the condition, such as an increase in breathlessness. The nurse

Are services responsive to people's needs?

(for example, to feedback?)

reviewed this information and, if needed, they arranged a joint visit with a GP from the practice to provide appropriate treatment. This demonstrated good working partnerships between the multi-disciplinary health team to provide effective treatment in response to a patient's change in condition.

Access to the service

We discussed the appointment system with the practice manager and two of the GPs. They told us that they had recently adjusted appointment times with the GPs and added extra sessions on each GP's list. They acknowledge there had been difficulties for patients in obtaining appointments to have a blood test. They advised us that a new health care assistant had started who was able to take blood samples and they planned to offer more sessions in the practice.

The majority of patients we spoke with said they still had problems when telephoning the practice first thing in the morning to book urgent appointments and some said they often drove to the practice to get an appointment.

Concerns & Complaints

The practice had an effective complaints procedure, which clearly set out what actions the practice would take if it received concerns. Information on how to make a complaint was displayed in the waiting room.

We reviewed the complaints log for the practice and saw it had received 10 complaints since April 2013. Concerns raised included lack of appointments to have blood tests, prescriptions not being available and not being able to get an appointment at a convenient time. Each concern had been investigated and where possible, improvements were made to prevent reoccurrence. The practice had recently employed a new member of staff to increase availability of blood testing appointments.

Patients we spoke with said if they had any concerns they would talk with the GP or practice manager.

Are services well-led?

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

Summary of findings

The practice requires improvement in its leadership.

Staff we spoke with considered that the practice leadership was open and supportive, but they felt there was not always the time available to carry out their duties effectively. This potentially could have an impact on patient experience.

There was a clear strategy in place for clinical governance arrangements, but improvements were needed on overall governance of the service provided.

There was an active Patient Participation Group (PPG) who considered they were listened and responded to when they suggested areas for improvement, even if the improvements could not be made.

Staff were not formally asked for their feedback in a survey, but considered they were able to raise any issues with the practice manager or GPs.

Although training for all staff was in place, there was no information on how often training should occur and whether this had been planned for. This did not ensure that all staff were competent to carry out their role.

There were suitable systems to monitor and manage risks to patients and staff, but these were not used consistently, which placed people at risk of harm.

Our findings

Leadership & Culture

All members of staff we spoke with described the culture in the practice as open and supportive. The management structure of the practice was flat with no senior roles identified in the staff team.

The geography of the building did not allow for all staff members to interact during the working day. Administration staff worked on a separate floor to reception staff. Some staff commented this had created a 'them and us' situation. We found that there was no clear oversight of the service provision. This meant that forward planning for the development of the practice was not cascaded to all members of staff effectively. Nurses were able to 'block out' appointment slots to ensure they kept up to date with paperwork, but often reception staff booked emergency appointments into these times.

The registered manager said that a review of GP appointments had improved patient experience. They added that they would review working arrangements to ensure staff had sufficient time to carry out their role and would look at employing the skills of their nurse practitioner more effectively.

Governance Arrangements

The Practice had a clear governance strategy for clinical outcomes. The governance was shared between the GPs who each had their own lead roles, for example, safeguarding and minor surgery. Each GP had also completed clinical audits on the effective treatment of conditions they specialised in, for example dermatology (skin conditions) and prescribing rates of antibiotics for respiratory (breathing) conditions.

One GP we spoke with told us that the out-of-hours provider sent daily information about patients they had seen to the patient's GP by email. Patients test results were coordinated by the administration team, along with any repeat prescription requests. There were systems in place to alert GPs if there were any concerns with test results or repeat prescriptions.

Systems to monitor and improve quality & improvement

The practice used information from its Quality and Outcomes Framework survey to monitor and improve quality. For example, in relation to potential

Are services well-led?

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

over-prescribing of broad spectrum antibiotics, they explained that they carried out a review of all patients who had been prescribed these medications and changes were made where necessary to ensure that the most appropriate treatment was in place.

Patient Experience & Involvement

The practice had an active Patient Participation Group (PPG) and we met with six members of this group. They told us they met every two months and in total there were 12 to 13 members. They said the GPs and practice manager attended the meetings. The group said that the practice dealt with any actions arising from meetings and gave feedback. They found it was a positive way of gaining information about the practice and the work of the Clinical Commissioning Group. They had noted improvements in the appointment system. The PPG wanted to have more information from the practice about care of patients with mental health conditions.

The practice carried out a patient survey in November 2013; this was coordinated by a member of the PPG. Comments about care received were positive and respondents considered they were not hurried when they attended the surgery. Concerns were raised about lack of appointments and availability of blood tests and the attitude of some receptionists. The practice had implemented an action plan to address these issues, which was on going.

Staff engagement & Involvement

Staff we spoke with said that they would share any ideas for improvement with the practice manager or the lead GP. The practice manager and GPs said that staff would discuss any concerns with them.

Staff told us that they have meetings every two months. They found this process useful and it enabled them to comment on the way the practice was run.

Learning & Improvement

Staff we spoke with said they were able to access online training to keep up to date. The nurse practitioner told us they were given protected time to ensure their professional qualification was up to date. The GP we spoke with confirmed they had opportunity to update their practice. The nurse told us they had five days of protected training in order to fulfil their registration requirements and had received an appraisal within the past 12 months. The practice's training programme demonstrated that training had been provided on areas such as basic life support and fire safety training. There was no information on how often training should occur and whether this had been planned for. This did not ensure that all staff were competent to carry out their role.

The practice manager told us that they were responsible for appraising all staff, apart from the nursing staff, this totalled 16 people. The practice manager worked 28 hours a week and considered that more appropriate arrangements could be implemented to ease this aspect of their workload.

All members of staff, apart from a new starter, had received an appraisal within the past 12 months. We noted that the health care assistant did not have a formal induction programme in place and arrangements had not been made if locum staff were required. The GPs we spoke with said they avoided the use of locum staff when possible, but recognised an appropriate induction pack should be in place.

Staff told us that the GPs and practice manager were approachable and they were able to discuss concerns they had over patient treatments.

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

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Home visits could be carried out if needed for patients who requested an appointment.

Appropriate arrangements were in place to provide care to patients at the end of life, and patients wishes were respected.

Our findings

We reviewed the practice's policies on safeguarding vulnerable adults. The policy described what constituted abuse and what actions staff should take if they suspected abuse had occurred in relation to older people.

GPs could make home visits for those patients who were not well enough to attend the surgery. Examples given included routine annual eye checks.

The GPs allowed time for a patient to walk to the consulting room if they had limited mobility.

We spoke with one GP about end of life care provided by the practice. They told us the practice had established links with the palliative care team and local hospice and met with them. They said that another GP who worked in the practice also worked at the hospice. The practice had carried out an audit of end of life care and found that the majority of patients who had chosen to die at home had their wishes respected and had done so. This was enabled by the support of the practice and the palliative care team.

For patients at the end of life, specific handover forms were used to provide information to out-of-hours providers and provision of anticipatory medicines. These are medicines which are used at the end of life to relieve symptoms, such as pain and sickness.

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

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Patients were able to access a telephone based consultations service to assist in managing their condition

Our findings

The practice used nurses employed by the Clinical Commissioning Group (CCG) to assist in managing some long term health conditions via telecare. They were responsible for providing education and advice to patients with long term respiratory (breathing) conditions, about managing their condition. The nurse also taught patients how to monitor the levels of oxygen in their blood and take their pulse. This information was input into a database, along with other information relevant to the condition, such as an increase in breathlessness. The nurse reviewed this information and, if needed, they arranged a joint visit with a GP from the practice to provide appropriate treatment. This meant that patients could receive specialist advice and treatment at a time convenient to them, and treatment in response to a change in their condition.

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

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Suitable arrangements were in place to care for pregnant women both before delivery and when the baby was born. Parents were consulted about treatment options and consider their concerns were listened to and an appointment was made promptly if needed.

Appropriate arrangements were in place for child health checks and support was made available for their parents.

Our findings

We reviewed the practice's policies on safeguarding children. We found the policy described what constituted abuse and what actions staff should take if they suspected abuse had occurred. This meant that there was clear guidance in place for staff to act on if they suspected a child was at risk of abuse.

Referrals were made by the practice for ante and postnatal care of expectant mothers. Parents who had children, said they were consulted about treatment options and involved in decision making. Parents who had made appointments for their young children considered that the practice had listened to their concerns and made sure they saw a doctor or nurse as quickly as possible. A separate form was provided to parents who had children who were registering at the practice. We saw this included detail on child health clinic sessions, breastfeeding support and contact details for the health visitors. This meant that appropriate care was provided both during pregnancy and after a baby was born and support when children were growing up.

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

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

The practice offered a range of appointment times and telephone consultations to suit patients working patterns.

Our findings

The practice offered extended opening hours for patients who were working.

The practice is open from 8.30am to 6.30pm on Mondays to Thursdays and 8.30am to 6.00pm on Fridays. Extended hours surgeries are held on Tuesday and Thursday from 7am to 8am and Wednesday evenings from 6.30pm to 7.30pm. The practice is unable to take telephone calls during extended hours surgeries.

Routine appointments can be made by telephone or online and are available up to six weeks in advance. Patients with urgent conditions can be seen on the day. The practice operates a duty GP system in the afternoons. Telephone consultations can be arranged for those who prefer not to attend the surgery.

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

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Our findings

We reviewed the practice's policies on safeguarding vulnerable children and adults. We found both policies described what constituted abuse and what actions staff should take if they suspected abuse had occurred.

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

There were suitable procedures in place to identify and report concerns if staff considered a patient was at risk of being abused.

Patients experiencing poor mental health were able to self-refer to other agencies when needed. Patients had access to counselling services and to a community psychiatric nurse if required.

Our findings

We reviewed the practice's policies on safeguarding vulnerable adults and children. We found both policies described what constituted abuse and what actions staff should take if they suspected abuse had occurred. There was also information that related to the risks related to people with mental health conditions.

The GP we spoke with said that patients with mental health needs were able to self-refer to other agencies if needed, if they considered their condition had worsened. The GP said that the good links they had with the local mental health hospital and mental health nurses made this an effective service.

The Patient Participation Group wanted more information from the practice about care of patients with mental health conditions.

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
Treatment of disease, disorder or injury	Regulation 11 HSCA (Regulated Activities) Regulations 2010 Safeguarding service users from abuse. People who use service were not protected against the risk of abuse because of inadequate policies and procedures. Regulation 11 (1) (a)

Regulated activity	Regulation
Surgical procedures	Regulation 11 HSCA (Regulated Activities) Regulations 2010 Safeguarding service users from abuse. People who use service were not protected against the risk of abuse because of inadequate policies and procedures. Regulation 11 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 11 HSCA (Regulated Activities) Regulations 2010 Safeguarding service users from abuse. People who use service were not protected against the risk of abuse because of inadequate policies and procedures. Regulation 11 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA (Regulated Activities) Regulations 2010 Requirements relating to workers. The registered provider did not operate effective recruitment procedures to ensure suitable people were employed for the purposes of carrying on regulated activities as there were no risk assessments in place for why some staff had not had a DBS check. Regulation 21 (a) (b)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
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Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (Regulated Activities) Regulations 2010 Management of Medicines. The registered provider did not protect patients against the risks associated with unsafe use and management of medicines as there were expired vaccines in the medicines fridge. Skin medicine was used for multiple patients from the same container. Regulation 13.

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