Old Road Medical Practice

Quality Report

145-149 Old Road,
Clacton-On–Sea,
Essex,
CO15 3AU
Tel: 01255 424334
Website: www.oldroadsurgery.org.uk

Date of inspection visit: 04 June 2015
Date of publication: 19/11/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
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

We carried out an announced comprehensive inspection at Old Road Medical Centre on 4 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe and responsive services, and requires improvement for providing effective services. It was also good for providing services to older people, people with long term conditions, families, children and young people, working aged people (including those recently retired and students), people whose circumstances make them vulnerable and people with mental health (including people with dementia). The practice is rated as requires improvements for providing services to people with long term conditions.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Improvements were needed in how safety alerts and significant events were acted on and monitored.
- Patients' needs were assessed and care was planned and delivered following best practice guidance and referrals to secondary care services were made in a timely way.
- Patients said they were treated with empathy, compassion, dignity and respect. They said that they were listened to and involved in making decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Complaints were dealt with appropriately and an apology offered when the practice got things wrong.
- Appointments were flexible to meet the needs of all population groups.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff were supported by management. The practice sought feedback from staff and patients.

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

Importantly the provider must:

- Ensure that patients' treatments and medicines are reviewed to minimise the risks of unsafe or inappropriate care and treatment.

The provider should:

- Implement a written procedure for managing, reporting and investigating significant events that includes arrangements sharing learning and identifies who is responsible for reviewing and monitoring learning so as to minimise risks.
- Ensure that staff who undertake chaperone duties complete training in respect of these.
- Review policies and procedures around handling of blank prescription pads.
- Ensure that policies and procedures are reviewed so that they reflect accurately the day-to-day management of the practice.
- Ensure that clinical audits are used to monitor and improve the treatment outcomes for patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There were appropriate policies and procedures in place, which staff had access to and followed to help keep patients safe. When things went wrong there were processes to investigate and learn from these incidents to help minimise recurrences. Improvements were required to ensure that safety alerts and serious significant incidents were managed and acted on consistently. There was no written procedure to describe how significant events were to be reported, acted on and reviewed. When these events were investigated it was not clear who was responsible for ensuring that improvements and learning was shared, reviewed and monitored so as to minimise recurrences.

The practice had safeguarding procedures in place and staff were trained to recognise and report any concerns about the welfare of adults and children. The practice was clean and fully equipped to treat patients in a safe environment.

Appropriate recruitment checks were carried out when new staff were employed. Staff were employed in appropriate numbers and trained to treat patients safely.

Are services effective?

Requires improvement

The practice is rated as requires improvements for providing effective services. Treatment was planned and delivered in line with local and national guidance for GP practices. Data made available to us including comparisons to other GP surgeries within the area showed that most patient outcomes were similar in relation to assessing and treating patients with long term conditions. However we found that clinical coding for hypothyroidism (underactive thyroid) was not always correct and some patients who were prescribed medicines for the treatment of this condition did not have their diagnosis recorded within the clinical computerised system. We also found that a number of patients had not had an annual blood test to ensure that their prescribed medicines were effective.

The practice did not have written protocols for repeat prescribing and its performance for prescribing some antibiotics, antidepressants and non-steroidal anti-inflammatory medicines was below the local and national averages. Some work was being undertaken by the practice to make the necessary improvements.

Summary of findings

The practice did not use routinely use clinical audits as way to monitor and improve outcomes for patients. However one audit which had been carried out within the previous 18 months improved the treatment for patients with high cholesterol when their medicine was changed.

The practice provided information in relation to health promotion and a full range of services including vaccination and screening programmes. The practice was performing in line with other GP practices both locally and nationally in delivering childhood immunisations and adult vaccinations including the annual flu vaccination.

The practice staff worked with multidisciplinary teams including community nurses, health visitors and social workers to improve outcomes for patients and ensure that they received coordinated care and support as needed.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the 2015 National GP Survey, published in the Friends and Family Test, and NHS Choices showed that patients rated the practice similar to others in the area for several aspects of care. Patients expressed mixed levels of satisfaction for how they were treated by GPs and nurses, their involvement in their care and treatment and being listened to. The practice had reviewed comments made by patients and discussions were held with GPs in order to make improvements and increase patient satisfaction where these were lower than expected.

Patients we spoke with during the inspection and those who completed CQC comment cards said they were treated with dignity and respect and they were involved in decisions about their care and treatment.

The practice considered the needs of patients and their families when patients were receiving palliative care and nearing their end of their life and supported families following bereavements.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and monitored and changed access to services to meet these needs. The appointments system was flexible and walk-in appointments were available between 11am and 1pm Mondays to Fridays. Pre-booked nurse appointments were also available each day at the branch surgery. Patients we spoke with during the inspection and those who completed CQC comment cards told us that they found it easy to

Summary of findings

make an appointment to see their preferred GP. The results of the 2014/15 GP Patient Survey also showed that patients were happy with access to the practice, opening times and ease of making appointments.

The practice was accessible to patients with limited mobility and disabled friendly facilities were provided. Patients were provided with information on how to complain. Complaints were investigated and responded to appropriately and suitable apologies were given to patients when things went wrong or they were unhappy with their experiences.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy to meet the individual needs of patients taking into consideration the health care needs of the local population.

The practice had a system of policies and procedures to help inform and support staff in their roles. Staff were trained and supervised and they told us that they received support and that the practice management was open and transparent.

There were arrangements for monitoring and reviewing how the practice was managed. The service was monitored and improvements made where needed,

The practice sought and acted on the views of patients and staff to make improvements to the services provided. There was a clear leadership structure and staff felt supported by management.

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

This practice is rated as good for the care of older people. Patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment and a full range of screening and vaccinations were available. Data showed that older people who were at risk of falls and fractures were prescribed bone sparing medicines to help reduce risks of fractures. The practice performance for diagnosing dementia was similar to other GP practices both locally and nationally. Patients with dementia had a face-to face appointment and an appropriate care plan in place.

The practice was proactive in offering seasonal flu vaccines to patients over 65 years and its performance in the delivery of the flu vaccinations was similar to GP practices nationally.

The practice identified patients who were at risk of avoidable unplanned hospital admissions and planned care in conjunction with other health and social professionals to prevent unplanned admissions. Regular multidisciplinary team meetings were held with other health and social care professionals to support patients and ensure that they received coordinated care and treatment.

Home visits by GPs and nurses were provided based upon patient's circumstances and needs.

People with long term conditions

Requires improvement

This practice is rated as requires improvements for the care of people with long term conditions and there are improvements that the provider must make. The practice provided assessments and treatments for patients with long term conditions which were in line with national and local guidelines. Data showed that the practice was performing in line with other GP practices both locally and nationally in the assessment and treatments of long term conditions such as diabetes and heart disease. There were arrangements for making sure that people with long term conditions had regular health and medication reviews. However we saw that some medical conditions were not coded properly in the clinical computer system resulting in medicines and health reviews not being carried out in a timely way.

When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments were flexible and walk-in services were available each day at the practice branch surgery. Ante-natal and post-natal checks were available. The practice monitored the physical and developmental progress of babies and young children, and weekly drop in sessions were held at the practice with the health visitor. Appointments for children were made available outside of school hours wherever possible. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes. Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). Appointments were flexible with telephone consultations, pre-booked appointments and a daily walk-in service. Patients who participated in the National GP Survey, those we spoke with and those who completed comment cards said that they were satisfied with the practice opening times and access to appointments.

NHS health checks for patients aged between 40 and 75 years were available and promoted within the practice and on their website. Nurse led clinics were provided for well patient health checks.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice recognised the needs of people who were vulnerable such as those with depression, alcohol or substance misuse issues, people with mental health conditions and those with learning disabilities. Longer appointments were available where patients required these. The practice took into consideration the needs of patients who were unable to attend appointments at the practice. GP and nurse home visits were provided to support these patients.

The GPs and nurses provided support and signposted patients to local and national organisations and agencies such as drug and alcohol services and bereavement support groups.

Summary of findings

Staff were trained and understood their responsibilities to report concerns about the welfare of patients to the appropriate agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice performed well when compared to others in diagnosing patients with dementia and ensuring that they had a face to face review and an appropriate plan of care with a referral to specialist services as needed.

People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams to support people experiencing poor mental health including those with dementia.

The practice had suitable processes for referring patients to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to Child and Adolescent Mental Health Services (CAMHS) as required.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the National GP Patient Survey results from 2014/15. Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received. We spoke with eight patients on the day of the inspection.

The results from the National GP Survey, Friend and Family Test and NHS Choices indicated that the majority of patients were happy with the practice, the appointments system and their involvement in making decisions about their treatment.

We received 24 completed 'Tell us about your care' comment cards. All of the patients who completed these expressed satisfaction with the care and treatment, and service they received. We also spoke with nine patients on the day of our inspection, one of whom was involved with the practice Patient Participation Group (PPG). A PPG is made up of a group of patient volunteers and members of a GP practice team. Patients told us that they were happy with the service and treatment they received. They said that they could access appointments that suited them and that they were treated with kindness and respect.

Areas for improvement

Action the service MUST take to improve

- Ensure that patient's treatments and medicines are reviewed to minimise the risks of unsafe or inappropriate care and treatment.

Action the service SHOULD take to improve

- Implement a written procedure for managing, reporting and investigating significant events that includes arrangements sharing learning and identifies who is responsible for reviewing and monitoring learning so as to minimise risks.
- Ensure that staff who undertake chaperone duties complete training in respect of these.
- Review policies and procedures around handling of blank prescription pads.
- Ensure that policies and procedures are reviewed so that they reflect accurately the day-to-day management of the practice.
- Ensure that clinical audits are used to monitor and improve the treatment outcomes for patients.

Old Road Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a Care Quality Commission practice manager specialist advisor and a Care Quality Commission GP specialist advisor.

Background to Old Road Medical Practice

Old Road Medical Centre is located close to Clacton Town Centre. The practice provides services for approximately 7,400 patients living within the Clacton area. The practice holds a Personal Medical Services (PMS) contract and provides GP services commissioned by North East Essex Clinical Commissioning Group. The practice has a branch surgery located at 103 Clacton Road, St Osyth Road, Clacton, Essex.

The practice population is similar to the national average for younger people and children under four years, working aged and recently retired and higher for older people aged over 75 years. Economic deprivation levels affecting children, older people and unemployment amongst the second highest in England. Life expectancy for men (79 years) and women (83 years) are in line the national averages. Their patient list has a higher than national average for patients with long standing health conditions and those of working age who are unemployed.

The practice is managed by two GP partners who hold financial and managerial responsibility for the practice and one long term locum GP. Three male GPs are employed, which includes one long term locum GP. The practice employs one nurse practitioner, three practice nurses and two health care assistants, a practice manager and a team of administrative, secretarial and reception staff who support the practice.

The practice is open between 9am and 6.30pm on weekdays with appointments available from 9am to 12pm and 2pm to 6.30pm. Extended opening hours are provided on Thursday evenings from 6.30pm to 8,30pm. The branch surgery offered GP on the day appointments each day between 11am and 1pm and pre-booked nurse appointments.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings, weekends and public holidays. Unscheduled out-of-hours care is provided by Primecare and patients who contact the surgery outside of opening hours are transferred directly to this service. This information is also available on the practice website.

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England and North East Essex Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 4 June 2015. During our visit we spoke with a range of staff including GPs, nurse practitioner, practice nurse, the practice manager, reception and administrative staff. We reviewed policies, procedures and other documents in relation to the management and day-to-day running of the practice. We spoke with patients who used the service. We talked with carers and family members. We reviewed comment cards, NHS Choices and National GP Patient Survey results where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that they were supported to raise concerns and that the procedures within the practice worked well.

There were systems for sharing safety received from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. These alerts have safety and risk information regarding medication and equipment often resulting in the review of patients prescribed medicines and/or the withdrawal of medication from use in certain patients where potential side effects or risks are indicated.

The practice manager told us that MHRA and other relevant alerts were forwarded to GP partners for review and to identify patients who may be affected. Staff had access to safety alert information in a folder on the shared computerised system.

Learning and improvement from safety incidents

There were no written procedures for staff to follow in relation to reporting, investigating and learning from near misses to help minimise the risks of safety incidents. Staff we spoke with said that the practice had an open and 'no blame' culture and they would record, and report any significant or untoward event to their line manager. We saw that reporting forms were available on the computerised system and hard copies were also available and staff were aware of where to find these. We reviewed the three significant events recorded and investigated within the previous 12 months. We saw that significant events were discussed at clinical meetings attended by GP's, nurses and the practice manager. We found that these events had been investigated and actions agreed to make improvements where this was indicated. Records from the events analysis did not include details of who was responsible for ensuring that identified actions were completed or show that these were reviewed to ensure that the appropriate action had been taken. Learning from when things went wrong was shared with staff.

Reliable safety systems and processes including safeguarding

The practice had suitable policies and procedures in place to identify risks to vulnerable children, young people and adults. All staff at the practice had undertaken appropriate safeguarding children and adults training. The practice had a dedicated lead GP who had oversight of the safeguarding arrangements. Staff we spoke with were aware of the practice procedures for protecting vulnerable patients. They knew how to identify signs of potential abuse or neglect in children, older and vulnerable patients and who to report these concerns to. Staff were aware of their responsibilities for reporting concerns to external agencies such as to the local safeguarding team if appropriate.

Information about vulnerable patients was shared with staff appropriately. GPs were appropriately using the required codes in electronic records to ensure risks to vulnerable adults and children and young people who were looked after (under the care of the local authority / in foster care) or on child protection plans were clearly flagged and reviewed. Information was used to make staff aware of any relevant issues when patients attended (or failed to attend) appointments. Records showed that information was shared with appropriate agencies including local social services, the police and health visitors as appropriate.

The practice had a chaperone policy, which was available and easily visible in the waiting room and consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Chaperone duties were carried out by nurses and health care assistants and on rare occasions administrative staff. Those staff we spoke with had an awareness of their responsibilities when acting as chaperones. Records we views and discussions with staff confirmed that staff had not undertaken training around chaperone duties and responsibilities. We found that Disclosure and Barring Services (DBS) checks had been carried out for staff who carried out chaperone duties.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were written procedures in place for the receipt, handling and

storage of temperature sensitive medicines such as vaccines to ensure that medicines remained effective and suitable for use. The minimum, maximum and actual temperatures of fridges used to store medicines were monitored daily. This helped identify any issues with the storage of medicines such as vaccines and other medicines which require cold storage to ensure that they did not exceed those recommended by the medicine manufacturer.

The nurses administered vaccines using directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directives and evidence that nurses had received appropriate training to administer vaccines.

Systems were in place to check medicines were within their expiry date and suitable for use and all the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line the practice medicines management policies. We found that blank prescription pads were not logged or audited so that risks of misuse were minimised.

We discussed the arrangements for the management of high risk medicines such as Lithium and Methotrexate (a medicine used to treat some types of cancers) which may have serious side-effects. Receptionists who were responsible for processing repeat prescription requests told us that they would rely on the clinical system to alert them to high risk medicines. They told us that they would pass these to the GP to review and agree. GPs we spoke with were unaware of any shared care arrangements for carrying out blood tests where patients care was primarily managed by secondary care (hospitals). They told us that they felt that the practice should be carrying out these tests and that they always followed up on any abnormal blood results.

Cleanliness & Infection Control

The practice had policies and procedures in place to protect patients and staff against the risk of infections. These included procedures for dealing with bodily fluids, handling and disposing of clinical waste, dealing with needle stick injuries and managing risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings). Records showed that all staff had last completed infection prevention and control training in 2013 and updates were scheduled for later in 2015. The practice had an identified infection control lead nurse who had undertaken appropriate training.

Patients we spoke with during the inspection told us that they found the practice was always clean and that they had no concerns. We observed the premises to be visibly clean and tidy. Hand sanitising gels were available for patient use. Hand washing sinks with liquid soap, sanitising gel and paper towel dispensers were available in treatment rooms and toilet facilities, as were posters promoting good hand hygiene. We saw records to confirm that patient disposable privacy curtains were changed on a regular basis. We saw that the practice had arrangements to segregate and safely store clinical waste including disposable instruments and needles at the point of generation until it was disposed of.

Staff were provided with appropriate personal protective equipment including disposable gloves and aprons. Spillage kits were available for cleaning and disposing of body fluids and staff we spoke with were aware of where to locate these when needed. Records showed that all clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise the risks of blood borne infections.

We saw there were cleaning schedules in place for daily, weekly and periodic cleaning tasks for general and clinical areas. Records were kept to show when cleaning had been carried out and these were audited on a weekly basis. The practice had arrangements for monitoring the infection control procedures and regular infection control audits were carried out to test the effectiveness of the procedures in place to protect staff and patients against the risks of infection. Following audits action plans were put in place, reviewed and updated to show that any areas for improvement were dealt with promptly.

GPs carried out minor surgical procedures such as skin excisions. We saw that single use disposable instruments were provided for all procedures and staff were trained in aseptic technique to minimise the risks of infections. Records showed that audits were carried out in respect of surgical procedures to help monitor and minimise the risks of infections.

Good

Are services safe?

Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of diagnostic and screening procedures, such as blood tests, respiratory, diabetes and well person procedures. Records we viewed showed that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested. All diagnostic equipment such as the INR monitor (used to monitor the effects of warfarin and the length of time it takes for blood to clot); spirometer, thermometers, ear syringe and the fridge thermometer were calibrated in line with the manufacturer's instructions so as to ensure that this equipment was fit for use. Through discussion with staff and a review of records we saw that equipment was replaced as needed.

Staffing & Recruitment

The majority of staff working at the practice had done so for many years. The practice had procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. We reviewed five staff records including GPs, nurses and administrative staff and found that these procedures had been followed. Appropriate checks including proof of identification, employment references and checks through the Disclosure and Barring Service (DBS) had been carried out for clinical staff. These checks helped to ensure that staff employed were suitable to work with vulnerable people. Pre-employment interviews had been carried out for more recently employed staff and checks made to ensure that GPs and nurses had appropriate qualifications and effective registration with the appropriate professional body, such as the Nursing and Midwifery Council (NMC) for nurses and the General Medical Council (GMC) for GPs. Inductions were in place for new staff so that they could familiarise themselves with their roles and responsibilities.

There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a staff rota in place and staffing levels were reviewed to ensure that actual staffing levels and skill mix were in line with planned staffing requirements. The practice had arrangements for providing staff cover in the event of unplanned absence due to illness and planned leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring Safety & Responding to Risk

The practice had robust arrangements for identifying and managing risks to staff and patients. There was a health and safety policy, which staff were aware of. Risks were identified through a variety of assessments, which covered fire safety, security of premises and records, medicines management, staffing levels and untoward issues which may impact on the running of the practice. These assessments were reviewed on annually or more frequently if required to ensure that the practice environment, equipment and staff practices were safe.

The practice had policies and procedures in place for recognising and responding to risks to patients. Staff we spoke with told us that they were aware of these procedures. For example staff had access to policies and procedures for treating sudden deterioration in patients including children and treating patients in the event of a mental health crisis. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had policies and procedures in place to manage medical emergencies. Records showed that all staff had received training in basic life support and clinical staff had anaphylaxis and electrocardiogram (ECG) training. Emergency medicines and equipment were available including access to oxygen, an ECG machine and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where to locate these in the event of an emergency.

Good

Are services safe?

Nurses checked emergency medicines and equipment each week and these checks were recorded. Staff had access to protocols for treating medical emergencies including anaphylaxis and cardiac arrest.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, adverse weather conditions, staff shortages or other circumstances that may affect access to the building or a disruption of the service. The plan described staff roles and responsibilities in the event of any untoward event. Staff we spoke with were aware of the plan and what action to take should the need arise. We saw that the plan contained relevant details and contact numbers to assist staff. There were robust arrangements for assessing and managing risks of fire within the practice. Regular fire alarm tests were carried out. Staff were trained in fire safety procedures. Records showed that fire safety equipment including extinguishers and alarms were tested and serviced regularly.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines including the National Institute for Health and Care Excellence (NICE), Clinical Commissioning Group guidelines and policies. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings. Records we viewed confirmed this. New patients were offered health checks when they joined the practice and staff proactively contacted patients where appropriate to attend for regular health checks and reviews.

GPs had lead roles for a number of long term conditions including heart disease, respiratory conditions and diabetes. They served as a source of expertise for colleagues in the practice and were responsible for ensuring new developments or specific clinical issues were discussed at the relevant practice meetings. There were a number of clinics held at the practice including those for asthma and chronic obstructive airways disease, family planning, minor surgery and diabetes. The nurse practitioner and practice nurses supported this work through nurse led clinics which allowed the GPs to focus on patients with more complex healthcare needs.

All GPs we spoke with used national standards guidance for patients with suspected cancers to be referred and seen within two weeks. We saw that regular discussions were held between GPs to discuss patient care and appropriate pathways for medical conditions such as diabetes and gastro-intestinal conditions to help ensure that appropriate referrals were made to secondary care services where appropriate.

Staff told us that information relating to patients who accessed the out-of-hours services and patients' test results were reviewed by GPs on a daily basis. We saw that when patients were discharged from hospital, their discharge summary letters were reviewed by administrative staff who made changes to prescriptions, which were then sent to the patient's GP to review and agree the changes.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, summarising patients' records, managing child and adult protection alerts and medicines management. Information was shared widely with staff and other healthcare professionals.

The practice participated in enhanced services commissioned by the Clinical Commissioning Group (CCG), Public Health and NHS England. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract to improve outcomes for patients). The practice kept registers of patients with learning disabilities, those receiving palliative care and patients who were identified as vulnerable or at risk of unplanned hospital admissions. Patients had care plans and the practice held regular multidisciplinary meetings which were well attended by external professionals such as the community nursing team to help ensure that patients were treated and supported appropriately according to their assessed needs.

Patients with long term conditions such as diabetes, asthma, chronic respiratory diseases and heart disease were reviewed through nurse led clinics and there was a comprehensive system for recalling patients for their review appointments. Data we reviewed showed that the practice's performance in assessing and treating the majority of patients with long term conditions was generally in line with or just below that the local Clinical Commissioning Group (CCG) and national averages. For example we saw that 100% of patients with atrial fibrillation, measured within the previous12 months were treated with anti-coagulation drug therapy or an anti-platelet therapy in comparison to 98.33% nationally. These medicines help to minimise the risk of blood clots and stroke that are associated with heart conditions such as atrial fibrillation. Data from the same period showed that the percentage of patients with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months was 71% compared to the national average of 77%. The practice performed similar to others nationally for other checks for diabetic patients. These checks help to ensure that conditions such as diabetes are well managed and that conditions associated with diabetes including heart disease are identified and where possible prevented.

Requires improvement

Are services effective?

(for example, treatment is effective)

The GPs did not have a clear understanding of clinical audits, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. There was no process in place for monitoring quality improvement through audits or reviews. One clinical audit had been carried out within the previous 18 months. The practice had reviewed cholesterol levels in patients who were prescribed Simvastatin and compared these levels after changing patient's cholesterol lowering medicine to atorvastatin. The results showed that in the majority of patients their cholesterol had reduced with the changes in medicines. This audit was repeated to monitor the effect of the changes in medication and the results showed that the majority of patients benefited from a reduction in their cholesterol levels.

The practice did not have any protocol for repeat prescribing in line with national guidance to ensure a consistent approach to the review of patients who were prescribed multiple medicines. We asked staff to run a search of patients who were prescribed Thyroxine (a medicine used to treat hypothyroidism). The search revealed 223 patients who were prescribed this medicine and who were not coded as having a diagnosis of hypothyroidism. We also found that there were numerous patients prescribed this medicine who had not had a blood test of thyroid function test within the previous 15 months to ensure that medicines were being prescribed in appropriate dosages to treat the disease safely.

Data we reviewed from 2013/14 showed that the practice had performed lower than GP practices nationally for some medicine prescribing such as use of frontline antibiotics and use of non-steroidal anti-inflammatory medicines NSAIDs (used to treat inflammatory conditions such as arthritis). For example the average daily prescribing of hypnotics was higher at 1.79 compared to .28 nationally and the number of Ibuprofen and Naproxen Items prescribed as a percentage of all Non-Steroidal Anti-Inflammatory drugs items prescribed was lower at 51.02 compared to 71.25. One GP told us that they had developed a practice medicines formulary to assist and guide GPs and nurses in prescribing. This formulary was due to be reviewed in 2015 and its effectiveness had not been monitored.

Effective staffing

The practice employed staff who were suitably skilled and qualified to perform their roles. All GPs were up to date with their yearly continuing professional development requirements. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All clinical and non-clinical staff had clearly defined roles within the practice and were able to demonstrate that they were trained to fulfil these duties. All staff undertook annual appraisals of their performance from which learning and development needs were identified. Records viewed showed that staff had individual personal development plans in place. Staff we spoke with were positive about the peer support arrangements and working relationships between all members of staff within the practice. The practice also had systems in place for identifying and managing staff performance and providing support and further training to assist staff should they fail to meet expected standards.

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patients' needs and support patients with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out– of-hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to which the relevant community health and social care professionals were invited to review and plan care and treatment for patients such as those who with life limiting illnesses and vulnerable patients. The out-of-hour's service had access to appropriate information to assist doctors to treat patients as needed when the practice was closed. The practice engaged with the local Clinical Commissioning Group for support and advice on issues relating to primary medical services.

Requires improvement

Are services effective?

(for example, treatment is effective)

Information Sharing

The practice had systems to share information with staff, patients and other healthcare providers. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. The senior GP partner told us that they were reviewing option for other systems available to find one which was more user friendly as staff reported some difficulties in running searches to review information about patients.

This system enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice used several electronic systems to communicate with other providers. For example, there were facilities for sharing patient records between GP practices when a patient registered or deregistered and the community nursing team and health visitors had access to the patient records where patients had consented to the sharing of their medical information. Electronic systems were also in place for making referrals to secondary care services such as specialist consultants. Staff reported that the systems were easy to use.

The practice provided patients with information about the option to opt out of the electronic Summary Care Records in readiness for when it was to be introduced. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or outside of normal hours.

Consent to care and treatment

The practice had policies and procedures in place for obtaining a patient's consent to care and treatment where patients were able to give this. The policy covered obtaining and documenting consent for specific interventions such as minor surgical procedures and vaccinations. GPs and nurses we spoke with had a clear understanding of these procedures and told us that they obtained patient's consent before carrying out physical examinations or providing treatments. We saw that where a patient's verbal consent was given this was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent procedures included information about people's right to withdraw consent.

Staff we spoke with understood the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties to meet the requirements of these legislations when treating patients. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing, where they were able to do so. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment). Patients we spoke with confirmed that their treatment, options available, risks and benefits had been explained to them in a way that they could understand. They told us that their consent to treatment was sought before the treatment commenced.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room with dedicated patient information boards. These included information to promote good physical and mental health and lifestyle choices including advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about the local and national help, support and advice services available. Information about the range of immunisation and vaccination programmes for children and adults, including MMR, shingles and a range of travel vaccinations were well signposted throughout the practice and on the website.

The practice offered a full range of health checks. All newly registered patients were offered routine medical check-up appointments. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Data we viewed for 2013/14 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests. For example data relating to 2013/14 showed that the percentage of children aged 12 months who had a measles, mumps and rubella vaccine (MMR) within this period was 93.1% compared to the local CCG average of 94.6%. The percentage of children aged five years who had an infant

Requires improvement

Are services effective?

(for example, treatment is effective)

meningitis C vaccination was 97.8% compared to the local CCG average of 95.8%. The practice also performed similarly to others within the CCG area for other childhood vaccinations and immunisations. We saw the percentage of women aged between 25 years and 64 years who had cervical screening test performed within the preceding 5 years was 83% compared to the national average which was 82%.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Each of the nine patients we spoke with during our inspection and 25 patients who completed comment cards said that all staff were caring and that staff listened to them and took their views and concerns into consideration. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014/15 National GP Patient Survey. 79% of patients who responded said that the receptionists were helpful. This was comparable to the local (86%) and national averages (87%). 73% said the last GP who they saw were good at treating them with care and concern and 94% said that nurses were. These results were similar to both local and national levels of patient satisfaction.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Reception staff dealing with telephone calls were mindful of patients in the waiting room and did not repeat any confidential or personal information during calls to maintain privacy and confidentiality of conversations.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager who would investigate.

Care planning and involvement in decisions about care and treatment

Nine patients we spoke with on the day of our inspection told us that they felt they were listened to and involved in discussions about their care and treatment. They told us told us that health issues were discussed in a way that they could understand and they felt listened. Patients told us that they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 25 comment cards we received was also positive with many patients describing very positive experiences about how they were treated by staff and their involvement in making decisions about their care and treatment.

We reviewed information from the 2015 National GP Patient Survey. 88% of patients who responded to the survey said that nurses were good at listening to them and giving them enough time involving them in decisions about their care and 89% said that nurses were good at explaining tests and treatments. These results were similar to other practices both locally and nationally. 88% of patients felt that nurses were good at listening to them. These results were similar to GP practices both locally and nationally. The results for GPs were less positive. 63% of patients said that the last GP they saw was good at giving them enough time and 62% said that they were good at listening to them. 60% said that GPs were good at explaining tests and treatments and 59% said that they were good at involving them in decisions. These were lower than other GP practices both locally and nationally where scores were around 80%. The practice manager and GPs told us that they had reviewed these comments and had discussed these at GP meetings to help improve patient satisfaction. This included reinforcing a culture of listening to patients and ensuring that treatments were explained in a way that patients could understand.

The practice had considered the needs of the local population group and had identified patients from ethnic minorities and those whose first language was not English. Staff told us that language interpretation services were available and they knew how to access these.

Patient/carer support to cope emotionally with care and treatment

Patients who we spoke with during the inspection told us that staff were caring and that they offered emotional support as needed. We saw that the practice worked proactively with other health and social care providers including local hospice services to enable patients who wished to remain living in their homes when their health deteriorated. We saw that patients receiving palliative care had individualised care plans, which were shared with relevant health care providers, including the out-of-hours service to ensure that patients received appropriate care as they approached their end of life.

Good

Are services caring?

The practice had procedures for supporting bereaved families and where families experienced bereavement their GP contacted them by telephone and appointments or home visits were arranged as needed.

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others due to illness or disability. Patients who were carers for others were identified at registration and provided with information to ensure they understood the various avenues of support available to them. Information in the patient waiting room, told patients how to access a number of support groups and organisations within the local area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to plan and deliver appropriate and responsive services. The practice had higher than local and national averages for patients who were confined to their homes and unable to attend appointments. The practice had a dedicated nurse to support these patients and they made regular visits to patients in their homes to monitor patients' health, particularly those patients who had terminal illnesses including those who were nearing the end of their life. This helped to identify deterioration in patients' health and to support patients at home, reducing the number of avoidable unplanned hospital admissions. Patients we spoke with told us that they were happy with the practice and that GPs and nurses were responsive to their needs.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds and patients whose circumstances made them vulnerable or hindered access to services. The practice population included patients who were unable to attend the surgery for appointments and patients with learning and physical disabilities. The practice offered a full range of health checks and access to telephone consultations and home visits.

The practice had policies and procedures for promoting diversity and equality. The majority of patients at the practice spoke English as their first language. The practice had access to language translation services (The Big Word) if required. A hearing loop system was available to support patients who used hearing aids and devices. The premises and services were suitable to meet the needs of patient with disabilities for example the entrance was accessible via an automatic door. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice as well as baby changing facilities.

Access to the service

Details about how to make, reschedule and cancel appointments was available to patients on the practice website. Appointments could be booked by telephone or in person. There were no facilities to book appointments online via the practice website and the senior GP told us that they were reviewing their computerised systems and website to facilitate this in the future. Appointments could be made up to two days in advance and the practice aimed to see patients within 48 hours. Same day urgent appointments were available. GP appointments were available between 9.30am and 10.30am and 4.30 to 6.30pm each day. The practice offered extended opening hours each Thursday evening between 6.30pm and 8.30pm. Nurse appointments were available between 9am and 12pm; and 2.30pm to 6.30pm. The practice offered a walk–in service at its branch surgery each weekday with GP appointments available between 11am and 1pm. Pre-booked nurse appointments were also available. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed they were put through to the out-of-hours GP service.

Each of the nine patients we spoke with during the inspection and those 24 patients who completed comment cards told us that they were happy with the appointment system and that they could usually see or speak with their preferred GP and same day appointments for urgent treatments if needed. We reviewed the data from the most recent National GP Patient Survey 2015. Results of the survey showed that the practice scored similar to GP practices nationally and within the local Clinical Commissioning Group area for patient satisfaction around getting through to the practice by telephone, ease of making and convenience of appointments. For example 75% said that they found it easy to contact the practice by telephone. This was higher than both the local and national averages of74%. 79% said that they got an appointment the last time they tried and 85% said that the appointment was convenient. These were comparable to local and national averages. The practice performed higher than other practices both locally and nationally to others in relation to patient satisfaction around waiting times and patients saying that they could see or speak with their preferred GP.

Listening and learning from concerns & complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Patients were provided with information to help them understand the complaints procedure and to raise complaints or concerns.

This information included details of how a complainant could escalate their concerns to the NHS England and the Health Services Ombudsman, should they remain dissatisfied with the outcome or if they felt that their complaints had not been dealt with fairly. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Patients we spoke with said that they had not needed to make a complaint about the practice.

We looked at a sample of complaints received by the practice for within the past 12 months and the practice responses to these. We saw that where complaints related to treatment that statements were obtained from the GP or nurse in question as part of the investigation into the concern and that this information was included within the response. Complaints were acknowledged and responded to within the appropriate timeframe. We saw that complaints had been investigated appropriately. Patients who complained had been offered the opportunity to meet with the practice manager or GP to discuss their complaint. Responses to all complaints we saw offered an apology and details of learning and changes to practice where this was appropriate. We saw that complaints were periodically analysed to identify trends or themes and learning was shared with staff.

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 and maintain patient centred healthcare with caring and love. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these.

The practice was active in focusing on outcomes for patients. We saw that the practice had recognised areas where they could make improvements and was making changes accordingly through work with the local Clinical Commissioning Group, conducting reviews and listening to staff and patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern its activity and these were available to staff. We looked at a sample of these policies and procedures, including those related to medicines management, infection control, staff recruitment and training, fire safety and patient confidentiality. The majority of these policies and procedures were bespoke to and reflective of the management and day-to-day running of the practice. We saw that improvements were needed to ensure that policies relating to medicines management including prescribing procedures.

Leadership, openness and transparency

The practice had a small team and there was a clear leadership structure with named members of staff in lead roles in several areas of patient care including medicines management and unplanned admission avoidance. Staff also took lead roles in infection control, safeguarding vulnerable patients and fire safety and health and safety. Staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. There was good communication between clinical and non-clinical staff. The practice held a range of regular clinical and non-clinical staff meetings to discuss any issues or changes within the practice.

Seeking and acting on feedback from patients, public and staff

The practice sought and acted on feedback from patients on a regular basis. It monitored the results of the NHS Friend and Family Test, and the National GP Survey. The practice reviewed comments made by patients and developed action plans to address any issues where these were raised.

The practice had an active Patient Participation Group (PPG) made up of patient representatives and staff from the practice who met three or four times each year. A PPG is made of practice staff and patients that are representative of the practice population who are involved in discussions and decisions about the range and quality of services provided by the practice. We spoke with one member of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. The PPG carried out patient surveys and the results from these were made available to patients, as they were displayed in the patient waiting area and on the practice website. The results from the most recent survey, carried out in 2014 showed that patients were satisfied with the services they received at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were supported to actively contribute and give their feedback, comments and suggestions.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff, all of whom confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Clinical staff told us that the practice supported them to maintain their professional development through training and mentoring. All the staff we spoke with told us that the practice was very supportive of training and that they had protected time for learning and personal development. Regular clinical meetings were held and consultants from the local hospital trust provided in-house teaching sessions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Patients were not always protected against the risks of unsafe or inappropriate care. Clinical coding for medical conditions were not consistently recorded in the computerised system. This resulted in some patients being prescribed medicines without regular medicine reviews or blood tests. This was in breach of regulation 12(1), 12(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.