Cairngall Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Requires improvement
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 Cairngall Medical Practice on 28 January 2015. We visited the main practice site at 2 Erith Road Belvedere Kent DA17 6EZ, and also carried out a brief visit to the branch surgery, Cumberland Drive Surgery at 58 Cumberland Drive Bexleyheath Kent DA7 5LB.

Overall the practice is rated as requires improvement. Specifically, we found the practice to require improvement for providing safe and caring services. It also required improvement for providing services for all the population groups we report on. It was good for providing an effective, responsive and well led service.

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

- Information about services and how to complain was available and easy to understand.
- In response to patient feedback, the practice was trialling a walk in service as part of morning surgery to provide patients with greater flexibility in accessing appointments.
- The practice had a number of policies and procedures to govern activity, and these were regularly reviewed. Staff knew the location of relevant policies and procedures and there was an audit trail that could demonstrate that staff had read relevant documents
- The practice proactively sought feedback from staff and patients.

The areas where the provider must make improvements are as follows:

- The provider must ensure suitable arrangements are in place for the management of medicines, including medicines used in medical emergencies.
- The provider must ensure risks to people's health are suitably assessed and acted upon

Summary of findings

- The provider must make improvements in response to relevant areas identified through the national GP patient survey in order to deliver a caring service

In addition the provider should:

- ensure the staff team have awareness of safeguarding adults from abuse, and that there is a responsible lead for safeguarding vulnerable adults.
- ensure the staff team are aware of the statutory notifications that must be made to the Care Quality Commission of relevant events.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There were enough staff to keep patients safe. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There were a number of improvements required in the management of medicines in the practice and in the arrangements for dealing with medical emergencies.

Are services effective?

Good

Nationally reported data, Quality and Outcomes framework (QOF) for the 2013 /14 year showed that the practice performed worse than the local average against a range of indicators relating to the care of patients, achieving an overall score of 76.9%. This figure was approximately 17% below the local area and national average scores. The practice told us this was because they had clinical and nursing staff shortages in that period.

For the 2014 /15 year, the practice performance had significantly improved and they achieved an overall score of 98%. The practice had achieved significant improvements in the ongoing monitoring and review of its patients. For example, 91.8% of patients diagnosed with Chronic obstructive pulmonary disease (COPD) had had an assessment of breathlessness in the last 12 months. of patients diagnosed with cancer, 91.7% had received a review in the preceding 15 months, or within six months of the practice receiving their diagnosis. For patients with asthma, 72.6% had received an annual review in the preceding 12 months which included an assessment of asthma control.

There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

The practice conducted a range of audits of patient outcomes, and audits had often been initiated due to initial concerns raised about a specific patient case.

Summary of findings

Are services caring?

Requires improvement 

Most patients we spoke with during our inspection told us they were entirely satisfied with the care and treatment they had received at the practice.

The responses we received from completed comments cards from patients using the practice were positive with patients telling us they felt the staff team worked hard, delivered good care, and that the environment was clean. Patients also mentioned specific members of staff and praised their helpful nature, attentiveness and professionalism. As well as the mostly positive comments, three comments cards also had less favourable comments which related to the new practice website, problems with getting appointments and long waits when using the walk in clinic.

We saw that staff treated patients with kindness and respect, and maintained confidentiality.

However, national GP patient survey data showed that patients rated the practice lower than others (locally and nationally) for some aspects of care. The areas that the GP patient survey results indicated improvements could be made related to some aspects of access, the quality of GP and nurse appointments and overall patient experience.

Are services responsive to people's needs?

Good 

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had listened to patient feedback about the difficulties in getting appointments that were suitable for them, and had recently started trialling a walk in appointment service. Urgent appointments were available on the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good 

There had been a high turnover of staff, GPs and GP partners in the practice in recent years.

As a result, we found that some systems relating to patient safety had not been appropriately implemented. For example, patient monitoring, medicines management and the lead roles such as for adult safeguarding were not being properly undertaken.

Summary of findings

However in recent months, the staffing in the practice had stabilised. There was a part time practice manager that had been in post for the last two years, working two days a week, supported by a deputy manager. A healthcare assistant (HCA) had recently been appointed in October 2014. Some of the HCA responsibilities included conducting annual and periodic health reviews for patients with long term conditions. These were some of the areas the practice's performance was shown to be lower than the local and national averages, according to QOF data.

The practice's stated aim on their website is to provide a friendly, caring, family doctor service.

The lead practice partner also articulated the practice ethos as to reach and meet the need of their practice population, and maintain and improve on the systems that support them in achieving this.

There was a clear leadership structure and most staff we spoke with told us they felt supported by management. Staff had received inductions, regular performance reviews and attended staff meetings.

The practice had a number of policies and procedures to govern activity which were reviewed and kept up to date. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. The practice was in the process of establishing a patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

We saw that the practice performed well against indicators relating to the care of older people. For example, the practice maintained a register of patients in need of palliative care, and had regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed. Patients aged 65 and older were offered a seasonal flu vaccination, opportunistically during other appointments, and they could also access specific clinics to receive vaccination. Between 01 September 2014 and 31 January 2015, 75.8% of the practice patients in the over 65 age group received seasonal flu vaccination. This was above the local area and national averages, which were 67.8% and 72.8% respectively. The practice also offered vaccinations against pneumonia and shingles, to help older people resist these conditions, and between September 2014 and January 2015 they had vaccinated 199 patients against pneumonia and 80 patients against shingles.

The practice had an established working relationship with the community health teams in the management of care for older patients.

The practice was implementing the admissions avoidance scheme, an enhanced service as part of their contract to support people at higher risk of avoidable hospital admissions to be properly supported and cared for in the primary care setting. For patients that had been recently discharged from hospital, the practice supported them through a 'virtual ward' led by their nursing team. The practice contacted patients within three working days of them being discharged to ask what help and support they needed that may help them avoid attending the emergency services department.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

The practice was responsive to the needs of older people, and offered home visits, longer appointments and rapid access appointments for those with complex care needs.

The practice is rated as requires improvement for the care of older people. We found the practice to require improvement for providing safe and caring services and that these findings affect people in this population group.

Summary of findings

People with long term conditions

Requires improvement

For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice provided us with information that personalised care plans were in place for patients with long term conditions.

Between 01 September 2014 and 31 January 2015, 58.7% of the practice patients of their patients aged over 6 months to under 65 years in the defined influenza clinical risk groups had received the seasonal flu vaccination; this figure was above the local and national averages of 47% and 50% respectively.

Nationally reported data, Quality and Outcomes framework (QOF) for the 2013 /14 year showed that the practice performed worse than the local average against a range of indicators relating to the care of patients, achieving an overall score of 76.9%. This figure was approximately 17% below the local area and national average scores. The practice told us this was because they had clinical and nursing staff shortages in that period.

For the 2014 /15 year, the practice performance had significantly improved and they achieved an overall score of 98%. The practice had achieved significant improvements in the ongoing monitoring and review of its patients. For example, 91.8% of patients diagnosed with Chronic obstructive pulmonary disease (COPD) had had an assessment of breathlessness in the last 12 months. of patients diagnosed with cancer, 91.7% had received a review in the preceding 15 months, or within six months of the practice receiving their diagnosis. For patients with asthma, 72.6% had received an annual review in the preceding 12 months which included an assessment of asthma control.

The practice is rated as requires improvement for the care of people with long term conditions. We found the practice to require improvement for providing safe and caring services and that these findings affect people in this population group.

Families, children and young people

Requires improvement

The practice provided the government recommended standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

The practice provided sexual health services, including advice and prescriptions for contraceptives, emergency contraception and pregnancy advice.

Between 01 September 2014 and 31 January 2015, 55% of the practice's pregnant patients received seasonal flu vaccinations; which was above the local and national averages of 39.5% and 43.9% respectively. Flu vaccines were also offered to children aged two, three and four years old at the practice, and 52%, 45% and 47% respectively had received flu vaccination between 01 September 2014 and 31 January 2015. The practice performance in flu vaccination among children was above the local area and national averages.

We saw good examples of joint working with health visitors. The health visitor attended the practice for one session a week, to provide support and advice to mothers of babies and young children.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, which involved the health visitor. There were monthly / six weekly meetings between the practice nurse and the health visitor to discuss the needs of any children under the age of five on the at risk register.

The practice is rated as requires improvement for the care of families, children and young people. We found the practice to require improvement for providing safe and caring services and that these findings affect people in this population group.

Working age people (including those recently retired and students)

Requires improvement

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this group.

The practice offered extended opening hours on Mondays and Tuesday evenings, and Thursday mornings. Saturday morning sessions were also provided for people with long term conditions.

A new walk in service was being trialled in the practice.

Summary of findings

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). We found the practice to require improvement for providing safe and caring services and that these findings affect people in this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice held a register of patients living in vulnerable circumstances including children on the at risk register, housebound patients, and those with a learning disability. It had carried out annual health checks for people with a learning disability and 17% of these patients had so far received a check up in the year to end 31 March 2015.

The practice had employed a healthcare assistant in October 2014, and their responsibilities included carrying out health checks for people with learning disabilities.

The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice had appointed leads in safeguarding vulnerable adults and children, who were the senior GP partner and practice nurse respectively. The GPs and practice nurse had level three training child protection. However they had not completed training in safeguarding adults. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. We found the practice to require improvement for providing safe and caring services and that these findings affect people in this population group.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

GPs in the practice carried out advance care planning for patients with dementia. However we saw that these were not consistently appropriately documented and that records did not show that the principles of the MCA 2005 had been taken into consideration.

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). We found the practice to require improvement for providing safe and caring services and that these findings affect people in this population group.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection, and most told us they were entirely satisfied with the care and treatment they had received at the practice. Patients told us they did not have concerns or reasons to complain about the service. Two patients we spoke with made some slightly less favourable comments; one related to the difficulties they experienced in obtaining test results as they were only made available by phone at specific times during the day, and the second relating to sometimes long waits in getting the phone answered to make an appointment.

We received 12 completed comments cards from patients using the practice, all of which were positive with patients telling us they felt the staff team worked hard, delivered good care, and that the environment was clean. Patients also mentioned specific members of staff and praised their helpful nature, attentiveness and professionalism. As well as the mostly positive comments, three comments cards also had less favourable comments which related to the new practice website, problems with getting appointments and long waits when using the walk in clinic.

The practice conducted regular patient surveys particularly themed around areas where there had indications they could make improvements. During November 2014, the practice conducted a survey of 100 patients at Cairngall Medical practice and 50 patients at Cumberland Drive branch surgery respectively. The response rates were 78% and 62% respectively. The survey had four questions asking patients how long they had had to wait for an appointment with a clinician (GP, nurse), the telephone to be answered and the issuing of repeat prescriptions. At Cairngall medical practice, a third of respondents said they had waited less than a week for an appointment, 12% had less than a two minute wait for the phone to be answered, 13% had their repeat prescription issued in less than two working days, just over a third of respondents had their repeat prescription issued in more than three working days. In response to waiting for their GP appointment, 12% said they were seen within 30 minutes of their booked appointment. The patients responding at Cumberland Drive branch surgery reported better experiences of accessing the surgery: 58% had less than a week wait for an appointment, 29% had less than a two minute wait for the phone to be answered, nearly a quarter had their repeat prescription issued in less than two working days, and 19% said they were seen within 30 minutes of their booked appointment.

Between 3rd October 2014 and 27 November 2014, the practice carried out its second survey on the length of time patients waited for the phone to be answered. Over the total of 40 working days, 3277 patients were asked how long they waited to be answered on the telephone. Seventy seven percent said they waited less than five minutes, 20% waited between five and 10 minutes, and the remaining 3% of respondents waited over 10 minutes. The practice found these results were an improvement from the first survey they had conducted on the wait time for the telephone to be answered. The first survey found 67% of respondents waited less than five minutes, 28% waited between five and 10 minutes and the remaining five percent waited more than 10 minutes.

The latest results from the GP patient survey indicated patients were seeing improvements in certain aspects of service access: 82% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, the local average from other GP practices was 80%.

The areas that the GP patient survey results indicated improvements could be made related to some aspects of access, the quality of GP and nurse appointments and overall patient experience. For example, 34% said they usually waited 15 minutes or less after their appointment time to be seen; 46% of respondents found it easy to get through to this surgery by phone and 60% of respondents described their overall experience of this surgery as good. The local averages for these responses were 57%, 64% and 79% respectively.

The practice had recently started the NHS friends and family test. They shared the results of the feedback they had received so far from this survey, and we saw that there were varied responses with similar numbers of respondents saying they would recommend the surgery as those that said they would not.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- The provider must ensure suitable arrangements are in place for the management of medicines, including medicines used in medical emergencies.
- The provider must ensure risks to people's health are suitably assessed and acted upon
- The provider must make improvements in response to relevant areas identified through the national GP patient survey in order to deliver a caring service

Action the service SHOULD take to improve

- The provider should ensure the staff team have awareness of safeguarding adults from abuse, and that there is a responsible lead for safeguarding vulnerable adults.
- The provider should ensure the staff team are aware of the statutory notifications that must be made to the Care Quality Commission of relevant events.

Cairngall Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included two GP specialist advisors, a pharmacy inspector and an expert by experience.

Background to Cairngall Medical Practice

Cairngall Medical Practice is a GP surgery in Belvedere, Kent. Its main site operates from purpose built premises with the ground floor comprising the receptions and waiting area, treatment and consultation rooms. The upper floor of the premises is designated for staff offices. Cairngall Medical Practice has its main site at 2 Erith Road Belvedere Kent DA17 6EZ, and a branch surgery, Cumberland Drive Surgery at 58 Cumberland Drive Bexleyheath Kent DA7 5LB.

The practice is registered with the Care Quality Commission (CQC) 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. The practice is able to provide these services to all groups in the population.

The CQC intelligent monitoring placed this GP practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice staff team comprised two male GP partners, two salaried GPs, two female practice nurses one of whom is a nurse prescriber, one male healthcare assistant, a practice manager, a deputy practice manager and a team of 16 administrative and receptionist staff.

At the time of our inspection the practice had 9846 registered patients.

The practice has a Personal medical Services (PMS) contract for the provision of its GP services to the local population.

The practice reception was open between 08.00am and 6.30pm, and appointments could be made during this period on Mondays to Fridays. Appointments were available between 08.00am and 5.50pm on Mondays, Tuesdays, Wednesdays and Fridays; and between 07.00am and 5.50pm on Thursdays.

The practice had opted out of providing out-of-hours services to their own patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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

We carried out an announced visit on 28 January 2015. During our visit we spoke with a range of staff (GPs, nurses, healthcare assistant, reception and administrative staff, and the practice managers) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used information to identify risks and improve patient safety. This included reported incidents, patient feedback, comments and complaints. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient raised their concerns with the reception staff about the welfare of a child in the practice waiting area. This was promptly escalated to the GPs and following further investigations action was taken to refer the child to social services and the community health visiting team where the family continue to receive support.

We reviewed incident reports and minutes of meetings where these were discussed during the 12 months before our inspection. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were discussed at staff meetings. There was some evidence that the practice had learned from these, however there were some gaps in implementing improvements in response to incidents. For example an incident had been recorded which occurred in July 2014 where there was a delayed referral of a vulnerable patient to social services due to difficulties accessing the patient; the patient refused the GP entry into their property on their first attempted visit, but allowed them entry a week later. The practice highlighted one of the lessons learnt from this incident as being the need for more vigilance around the safeguarding of vulnerable adults. At the time of our inspection in January 2015, no additional training and awareness sessions had been arranged for the staff team.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the staff meetings and they felt encouraged to do so.

Staff used incident forms on the practice's electronic recording system and sent completed forms to the practice manager. The manager was able to show us the system used to manage and monitor incidents.

The practice manager told us they had the lead responsibility for sharing national patient safety alerts with relevant members of staff. However when we spoke with nursing staff they gave us an example of a medicine safety alert they had learnt about from a medicine supplier when they had tried to order the item. This showed that alerts were not always being received by relevant members of staff internally. The practice nurse told us they intended to sign up themselves to receive the medicines safety alerts directly in the future.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on child safeguarding. Members of medical, nursing and administrative staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed leads in safeguarding vulnerable adults and children, who were the senior GP partner and practice nurse respectively. The GPs and practice nurse had level three training child protection. However they had not completed training in safeguarding adults. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in 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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The practice identified and followed up children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers).

The practice had a system to highlight vulnerable patients, including identifying children and young people with a high number of A&E attendances. There was follow up of children who persistently failed to attend appointments, such as for childhood immunisations.

Medicines management

We found that the practice sought the expertise and support of a pharmacy advisor. This was primarily to help them review incentive schemes, and arrange and deliver audits and training. With the support of the pharmacy advisor, the practice had carried out audits of certain medicines including methotrexate, lithium, pregabalin / gabapentin, as well as specialised dosing regimen such as sip feeds, stoma appliances, and long acting insulins and inhaled high dose steroids. The practice management told us that the findings of medicines audits were discussed at clinical meetings, and the recommendations made as a result were implemented.

Following these medicines audits some changes had been recommended by the practice's pharmacy advisor. These included the recommendation for methotrexate to be classified as an acute prescription item. This change that would prevent it being issued as a repeat prescription had not been implemented. Once the change had been implemented, patients using this medicine would then be required to have a GP appointment before they were prescribed it and the GP would carry out necessary checks to make sure it continued to be suitable for them to use. Warning flags in the electronic system were in place for methotrexate and lithium prescribing. This alerted staff that these medicines required additional checks to be carried out before repeat prescriptions were issued for them. There were also further plans for receptionist training on prescriptions.

The pharmacy advisor attended the practice clinical meetings every two months to provide continued expertise in medicines management.

There was tracking of all controlled drug prescriptions issued in the practice. The patient (or their representative, or local pharmacy) had to sign when they picked up the prescription script for a controlled drug.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. The procedures for maintaining the 'cold chain' of certain medicines was covered as part of induction training.

We found that vaccines were appropriately managed. There were designated fridges for storing these medicines and they were clean tidy and well monitored. There was good rotation of vaccine stock and a weekly expiry date check. The practice staff used an electronic drug expiry log, which was updated with each new stock delivered. However, we found that some existing stock had not been added to the drug expiry log.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

However we found that in some aspects, the practice must improve the way they manage medicines: the management of repeat prescriptions, emergency medicines and safety alerts relating to prescribed medicines.

We found that the practice had trained some administrative staff to act as prescription clerks. The prescription clerks could generate prescriptions at patients' requests, and they were then given to the GP to sign thereby authorising the prescriptions. We found that the system in place allowed the prescription clerks to generate both acute and repeat prescriptions. The acute

prescriptions the clerks were able to generate included bandages, dressings, swabs and nicotine replacement products. There was also a potential for the clerks to generate prescriptions for other medicines such as asthma inhalers. Staff told us that acute prescription scripts were flagged to the GP, and the senior GP partner told us it was clear from the electronic system what type of prescription was being requested. However when hard copies were sent to be signed it was not always clear whether they were acute prescriptions. There was therefore a risk that acute prescriptions generated by prescription clerks did not receive the required scrutiny by the GPs before they were authorised.

In the practice, we found that the prescription clerks could re-authorise a repeat prescription after the maximum number of times set by the GP. For example our pharmacy inspector saw a prescription for an antibiotic drug with a maximum dispensing of one. When the inspector asked the prescription clerk what they would do if the patient asked for the medicines again, they responded that they would re-issue a new prescription and send it to the GP for authorisation. The clerk told they inspector they would make clear to the GP that this is what they had done with the prescription.

We found a number of high risk medicines (those with serious side effects), including methotrexate, lithium, warfarin and azathioprine, were on the repeat prescription system. This meant that prescription clerks could re-issue them for GP authorisation without being assured that the correct pre-requisite checks, such as blood tests, had taken place. The practice could therefore not be sure that the correct monitoring of patients was taking place as part of the medicines prescriptions process. The senior GP partner told us that the practice needed to do a risk assessment around repeat prescribing of high risk medicines.

FP10 forms are the prescription forms used for patients that can be taken to any community pharmacy to be dispensed. These prescription forms should be controlled stationery because stolen or counterfeit prescription forms may be used to obtain drugs of abuse and other items. We found that FP10 forms were not tracked once they have been received by the practice. The forms were stored in a locked cupboard but neither the pads nor blank computer scripts have records maintained that tracked their usage. There were 10 printers within the practice where the forms were distributed to, one of the printers was in the reception area which was unlocked. The practice did not have a policy in place for the monitoring and tracking of the FP10 forms.

Emergency medicines were available in a secure cupboard in a treatment room. Staff told us that the emergency medicines were checked on a monthly basis. However, we found two lots of expired medications in the emergency cupboard: five vials of Benzylpenicillin (used for the treatment of suspected bacterial meningitis) and some Salbutamol nebulisers (used in the treatment of asthma) had expired at the end of September 2014. We also found that there was no aspirin or chlorphenamine available in the emergency drugs cupboard and there was no list of the medicines the practice kept for dealing with medical emergencies. Whilst there is not a mandatory list of medicines that a practice must hold for managing medical emergencies, there are published guidelines for emergency drugs in GP practices. The practice should have in place evidence that an appropriate risk assessment has been carried out to identify a list of medicines that are not suitable for them to stock, and how this is kept under review.

Following our inspection, the practice manager wrote to us to inform us that there is also an emergency bag available in the practice which we were not shown at the time of our inspection. They told us that the bag contained Aspirin, two ampules of Adrenaline and two glyceryl trinitrate GTN sprays (used to treat chest pain and discomfort).

We found that the nurse's treatment room did not have an up to date copy of the British National Formulary (BNF) available for adults or children or online access to it. The BNF is an essential reference publication for clinical staff that aims to provide prescribers, pharmacists, and other healthcare professionals including those who administer medicines, with sound up-to-date information about the use of medicines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with did not raise any concerns with us about cleanliness or infection control.

The practice had a lead for infection prevention and control (IPC), who was the practice nurse. At the time of our

inspection the practice nurse was due to have an update training in Infection prevention and control, as the session they had planned to attend had been rescheduled to March 2015.

We saw the report of an external infection control audit, arranged by the clinical commissioning group, which had been completed for the practice November 2014. The practice had been found to be meeting suitable infection prevention and control standards in most of the areas reviewed at the inspection including the environment, hand hygiene, waste management, management of specimens and the maintenance of clinical and minor surgery rooms. The IPC lead told us they had not carried out any IPC audits yet since taking on the lead role responsibilities.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There were also policies in place relating to other IPC areas, including for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in the consultation and treatment rooms.

The practice had arrangements in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records of risk assessments and guidance for minimising risks at the main branch surgeries, which had been undertaken in April 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, which was April 2014. A schedule of testing was in place.

We saw evidence of calibration of relevant equipment, including weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. These checks had been carried out in December 2014. The retest date for the medicines refrigerator is July 2015.

Staffing and recruitment

Staff records showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and registration with the appropriate professional body. Criminal records checks through the Disclosure and Barring Service (DBS) were undertaken for the newest members of staff, and the practice was undergoing a process of retrospectively carrying out DBS checks for longer serving members of staff. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies, but there were some required improvements in the management of medicines used in medical emergencies. This is discussed in more detail in the section on the Management of medicines.

Requires improvement

Are services safe?

Records showed that most of the staff team had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The practice managers told us part of their continuity arrangements included accessing agreed support from their five local practices they are a part of, to ensure they can continue to provide care to patients. The practice also had insurance arrangements in place that would provide temporary arrangements for them to continue operating if there is an interruption in services that could be delivered at their premises. The practice operated from a main site and a branch surgery, so could use one of those sites exclusively if there was an interruption at the other site.

The practice had fire safety arrangements in place, including an annual fire alarms systems check, which was last carried out by an external contractor in November 2014. Records showed that staff carried out monthly fire systems checks. However there were no records of fire drills being conducted in the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The clinical team in the practice monitored the prevalence of chronic diseases in the practice population, and made arrangements to ensure people's needs would be met. For example they recognised that they had higher numbers of diabetic patients and hypertensive patients than national averages; 7% of the practice population was diabetic, whilst the national average was 5%, and 14.83% of their patients were hypertensive whilst the national average was 13.7%. They had therefore implemented a recall system for these patients, where they were offered review appointments. These reviews were also offered opportunistically to these patients when they attended GP appointments for other reasons.

Diabetes can reduce the blood supply to people's feet and lead to foot injuries not healing well. Checks for feet health are recommended as part of the annual review for diabetic patients. At the time of our inspection, the practice had succeeded in providing foot checks to 65% of its diabetic patients for year April 2014 to March 2015. Those patients that had not yet received the foot check in the year were being offered review appointments. Other checks carried out as part of the annual reviews for diabetic patients include blood pressure checks, eye checks and record and advice if they are smokers.

We found there were no care plans in place for patients with certain conditions, where published guidelines and contractual obligations indicated they should have them. For example we reviewed the record of a patient living with dementia and found that there was an entry in their records that they had received a care plan and annual review. However there were no details records of the outcomes of this consultation, or documentation of their plan of care over the coming months.

Management, monitoring and improving outcomes for people

Nationally reported data showed that the practice performed worse than the local average against a range of indicators relating to the care of patients. The Quality and Outcomes Framework (QOF) to measure its performance. The latest published QOF data for this practice, for the year 2013 / 14, showed it performed below the local area and national averages achieving an overall score of 76.9% which was 17.1 percentage points below CCG average, 16.6 percentage points below England average. For particular conditions including Asthma, Chronic obstructive pulmonary disease (COPD), Diabetes and Hypertension, the practice performance in the care of patients in these groups needed to be improved.

For the 2014 /15 year, the practice performance had significantly improved and they achieved an overall score of 98%. The practice had achieved significant improvements in the ongoing monitoring and review of its patients.

The practice implemented a call and recall system for patients at risk of diabetes and those diagnosed with diabetes. The practice sought to improve health outcomes for these patients by, for example offering them an annual foot examination as part of their health reviews. The lead GP and deputy manager ran weekly searches of the electronic records system for diabetic patients who had not received a review involving a foot health check in the last twelve months and invited them to attend the practice for a review appointment. The patients were also invited to provide a blood sample ahead of the appointment so that the results could be discussed as part of the review.

The practice recognised that their performance in the care of patients with hypertension could be improved. They attributed this to the vacancy they had for a health care assistant in the previous 12 months. This meant that the diabetic patients had not been actively targeted for health reviews. Since the recruitment of a healthcare assistant in October 2014, they had started to make improvements in the additional care and support offered to diabetic patients through health reviews.

The practice has a system in place for completing clinical audit cycles. The practice provided us with examples of clinical audits they had recently undertaken, one for

patients prescribed lithium and one for the care of patients being treated for prostate cancer. Both audits had been initiated due to initial concerns raised about a specific patient case.

The prostate cancer audit was prompted due to a patient case being lost to follow up. An audit was therefore carried out on all the practice patients with cancer of the prostate to investigate whether any other patients had also been lost to follow up. The audit found that 60 prostate cancer patients were currently on the practice list, and that 31 had had a documented prostate specific antigen (PSA) test within the last year and were being followed up. The remaining 29 patients had no record of a PSA test in the last year, so further investigation was carried out into their care. Their records showed they were all being followed up and were under the care of the hospital Urology team, with the exception of one patient who was having their treatment at a private hospital so had not been followed up by the practice. Following the audit, this patient was invited for an appointment and to have blood tests completed.

The lithium audit was prompted by the GP observing whilst signing repeat prescriptions for lithium that most of these patients had not had recommended periodic checks carried out for them. The British National formulary (BNF) guidelines state that the patient's lithium level should be checked every three months, and that their Urea and Electrolytes (U&E) and Thyroid Function Test (TFT) should be carried out every six months. The audit found that nine patients were prescribed lithium in the practice, and had all been on the treatment for more than one year. Following a review of each patient's latest blood results and clinical events, the practice was able to determine the reviews each patient had received. They found that 44% had had their lithium levels checked more than more than three months ago. The audit also identified that 22% of patients had lithium levels outside of the reference range, and 11% had sub therapeutic lithium level. Following the audit, recommendations were made to add warning notes to the patient records for each patient receiving lithium treatment, with reminders for three monthly lithium level checks, and six monthly U&E and TFTs. A letter was also sent to each patient on lithium reminding them to attend the practice for three-monthly blood tests to monitor their lithium levels. The practice planned to re-audit in six months to check that the care they provided to lithium patients was now in line with published guidelines.

A GP in the surgery undertake minor surgical procedures in line with their registration and NICE guidance, and had been appropriately trained and kept up to date with their professional development needs. They also regularly carried out clinical audits on their results and used this information in their learning. The practice was accredited to provide minor surgery procedures under their contracted Direct enhanced services (DES) from 01 April 2014.

Patients' allergy information was included on their electronic record.

Patients were able to order repeat prescriptions in a number of ways: Online, via web pages and through their electronic system. Paper repeat prescription requests could be made in person in the practice. When the practice was closed the request could be left in a designated secure box outside the practice premises. Local pharmacies were able to make repeat prescription requests for patients.

Prescriptions were date and time stamped to ensure that they make the 48 hour target. We reviewed four correspondences from clinic appointments, discharge letter and following A&E attendance and found all actions relating to the issuing of medicines had been completed within an acceptable timeframe.

During our inspection, we had concerns that patients who were treated with Warfarin were not followed up appropriately to ensure there was suitable monitoring was taking place before they issue the repeat warfarin prescriptions. The practice management team explained to us that all patients who need Warfarin were referred to the community anticoagulation clinic via the Choose and Book system. One of the community anticoagulation clinics is held at Cairngall Medical practice. The practice manager told us these patients had their blood tests taken at the clinic and their warfarin doses are changed by the clinic if appropriate. Following these clinics they had the information about the care and tests they received sent to their GP, for the GP to action any change of medication as necessary. Following our inspection, the practice management team made arrangements with community anticoagulation clinic team for all their patients who attend the Warfarin clinic at their practice to have their latest INR reading and any changes notified to the practice at the end

Good

Are services effective?

(for example, treatment is effective)

of the clinic session. The practice management told us that these results would be entered onto the patients notes immediately, thus ensuring that the most recent information in on the notes for the clinician.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, data from November 2014 for the North Bexley locality area, that the practice is within, compared prescribing, A&E attendance, Choose and Book referrals and Individual funding requests. The data showed that Cairngall Medical Practice was not an outlier for any of the data comparisons.

Effective staffing

The practice is normally staffed by three GPs at the main site, and one GP at the practice branch site. The healthcare assistant worked at the branch site during the morning and at the main site in the afternoons.

There were two nurses in the practice, one was a nurse prescriber. Nursing staff had received additional training in the management of certain long term conditions, such as diabetes. The practice had additional nursing staff from the community team. There was an additional practice nurse from the community health team who came in once a week, and on Thursdays the practice nursing team ran a diabetic clinic.

The practice had appointed a healthcare assistant (HCA) in October 2014. Some of the HCA responsibilities included conducting annual and periodic health reviews for patients with long term conditions.

There had been staffing changes in recent years in the practice but over the past 18 months, the staffing in the practice had stabilised. There was a practice manager that had been in post for the past two years, supported by a deputy manager.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice's policy was that responsible administrative staff would open, read, share and act on any issues arising from communications with other care providers. They aimed to act on all communication and correspondence on the day they were received, and allocate to the GPs for action. The GP who saw these documents and results was responsible for the action required. When we spoke with the lead GP about the review of allocated correspondence and results to him, he told us that due to his other responsibilities in the practice he was able to review the results on a once weekly basis.

There was a designated member of the administrative team who managed all incoming correspondence into the practice. There was also a member of staff responsible for scanning and summarising paper correspondence before it was assigned to other members of staff (such as the GPs) or filed in patients' electronic records. We spoke with the members of staff responsible for the incoming correspondence and scanning of correspondence. They were able to describe to us what their role entailed and told us that it involved some degree of decision making in terms of what was passed on to clinicians for review and what was stored directly onto patient records without review.

Whilst the staff members with these responsibilities had been working in these roles for some time and had received training from more senior staff, there were no formal protocols or procedures in place guiding staff on how to make decisions about which correspondence needed to be seen by the doctors and which could just be filed for reference. We found this meant there was a risk of information not being seen by the doctors that should have been, and necessary actions not been taken possibly leading to delays in care and treatment.

We reviewed some on the clinical letters that had been received on the day of our inspection, and found that some contained diagnoses had not been coded onto the patient records.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, most of whom

Good

Are services effective?

(for example, treatment is effective)

were receiving an integrated package of care. These meetings were attended by other professionals involved in their care including district nurses, social workers, and palliative care nurses. Decisions about care planning were documented and shared with the attending professionals.

The practice nurse held monthly or six weekly meetings with the health visitors. The nurse told us they make the rest of the clinical team aware of when the meeting was happening to give them opportunities to raise any cases for discussion. The nurse commented on the usefulness of this meeting in supporting children under the age of five who might be vulnerable. The nurse also highlighted that there were no current meetings with the schools to be able to provide the same level of support to children in older age groups. The nurse also agreed that a GP presence at the health visitor meetings would be beneficial, as had been the case in the past.

Information sharing

Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice also had an intranet based electronic information management system, which was used for documents management, record keeping, incidents management and other functions supporting staff in their day to day work in the practice.

Staff were able to talk us through the processes they followed to ensure that patient information received, such as test results, were seen and acted on. An electronic system was used for the management of this information. Test results were allocated to the GPs to review and act on, by members of the administrative team. The GPs we spoke with told us they actioned their results daily. However the lead GP told us that due to their multiple responsibilities they reviewed their allocated results on a once weekly basis. He told us that if the slightest risk to patient care were to become apparent using this system a Significant Event Analysis would be raised and the whole process would be re-assessed and redesigned as required.

Consent to care and treatment

We found that staff were not fully aware of the Mental Capacity Act 2005 (MCA 2005) and their duties in fulfilling it. The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.

However the practice lead GP was able to demonstrate to us that they sought advice and involvement from other relevant professionals and interested parties in the care of patients who lacked capacity to make decisions about their care. They provided us with an example of a case where a Do Not Attempt Resuscitation (DNAR) notice had been applied to a patient record. A meeting was arranged with the psychogeriatrician, the GP, the social worker, the daughter and the patient. The geriatrician carried out a documented mental capacity assessment, and end of life decisions were made with the patient's family involvement, and were recorded.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and referring smokers for smoking cessation advice sessions with the healthcare assistant. The healthcare assistant was also trained to advice patients on weight reduction, and the GPs referred patients opportunistically for this service as well. At the time of our inspection, 99.87% of patients aged over 16 with a smoker status record as smoker who were offered smoking cessation advice.

Good

Are services effective?

(for example, treatment is effective)

All patients newly diagnosed with diabetes were referred to the practice health promotion clinic.

The practice also referred patients for other programmes and services they were not able to offer at the practice, such as the local NHS exercise referral scheme and to the dietician at the local hospital.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. As of the time of our inspection, 17% of patients on the learning disability register had received an annual health check in the current year (ending 31 March 2015).

The practice provided cervical screening to its eligible patients according to national guidelines. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. At the time of our inspection, the practice cervical screening uptake was 77.1 % in 25-49 year olds over three and a half year coverage, 79.8% in 50-64 year olds over five and a half year coverage and 78.0% for 25-64 year olds over three and a half to five and a half year coverage.

The practice undertakes screening programmes for breast and bowel cancers. Their bowel screening uptake was 51.0% for the 60 to 69 year olds, which was a two and a half year coverage of 54.5%. For the 60 to 74 year olds, the uptake was 50.4% which was equivalent to a two and half year coverage of 48.6%. The Breast screening uptake for 50 to 70 year olds was 55% with a three year coverage of 76.0% and for 47 to 73 year olds the uptake was 55% with a three year coverage of 61.2 %.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Information about these services was available on the practice website and in the practice leaflet.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the national GP patient survey published on 8 January 2015, and collected during January to March 2014 and July to September 2014. The results from this survey showed that patients rated the practice lower than others (locally and nationally) for some aspects of care. The areas that the GP patient survey results indicated improvements could be made related to some aspects of access, the quality of GP and nurse appointments and overall patient experience.

For example, in response to their GP treating them with care and concern, 67% of respondents said they were good or very good; the local average was 78% and the national average was 82%.

Close to half of respondents, 47%, had confidence and trust in their GP, and 36% reported having some degree of trust in their GP. The local and national averages in the survey were higher with 57% and 64% respectively having confidence and trust in their GP; although they were similar for people having some degree of trust in their GP at 33% and 29% respectively.

Patients' ratings of the nurse listening to them was below the local and national average, with 66% of respondents saying the nurse was good at listening to them, whilst he local and national averages were 78% and 79% respectively.

In addition, 28% would not recommended the surgery and 19% were not sure if they would recommend it. The average for those responding in the same manner in the local area was lower, with 14% saying they would not recommend and the same proportion being unsure if they would recommend their surgery.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 12 completed comments cards from patients using the practice, all of which were positive with patients telling us they felt the staff team worked hard, delivered good care, and that the environment was clean. Patients also mentioned specific members of staff and praised their helpful nature, attentiveness and professionalism. As well as the mostly positive comments, three comments cards also had less favourable comments which related to the new practice website, problems with getting appointments and long waits when using the walk in clinic.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However we observed that the reception area where the staff were based was not secure, and confidential information and records were kept in that area.

We observed staff interactions with patients as they arrived in the waiting for appointments, or made enquiries at the reception desk. We found staff to be courteous and professional in their interactions with patients.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they received good care and treatment. Patient feedback from the comment cards we received was also positive and aligned with these views.

However the results of the national GP patient survey information suggested the practice needed to make improvements in patient involvement in decisions about their care and treatment. The survey results showed 57% of practice respondents said the GP involved them in care decisions. This result was below the local area and the national averages, which were 70% and 74% respectively. In addition, 66% felt the GP was good at explaining treatment and results, which was also below the local and national averages of 80% and 82% respectively. According to the survey none of the practice respondents said the GP was poor at involving them in decisions or sharing information about tests and treatments, but a quarter of respondents felt the GP was neither good nor poor in these areas.

All those responding to the survey told us they did not have a written care plan in place, and half of those responding stated that they had a long term health condition. However approximately half of these respondents said they had had enough support from local services and organisations to help manage long-term conditions within the last six months and the remaining respondents said they had not needed such support.

Requires improvement

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient and carer support to cope emotionally with care and treatment

Patient feedback from the comment cards was positive about the caring and supportive nature of the staff team.

There were notices and information leaflets available in the waiting room, and health information and health promotion advice available on the practice website.

The practice had a healthcare assistant who undertook health checks and assessments, and offered additional support for patients with long term conditions and multi-morbidities. These patients were assessed for risk of anxiety and depression and referred for additional support if required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from its patients. In October 2014 they introduced a walk in service as a more flexible format for accessing appointments during morning surgeries. Bookable appointments also continued to be offered alongside the walk in service.

The practice had recently started a virtual patient participation group (PPG). At the time of our inspection, there were 13 members signed up to the PPG. The practice manager told us that they were intending to write to the group to seek their involvement in the next steps for the PPG.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The healthcare assistant in the practice could communicate in British Sign Language and Makaton. Makaton is a language programme using signs and symbols to help people to communicate.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice had wide doorways, a ramp to the entrance for wheelchair users and specially equipped disabled toilet facilities.

The practice was situated on the ground and first floors of the building. Services for patients were located on the ground floor, and the first floor was for staff use only. There was stair access only between the floors.

Access to the service

The practice reception was open between 08.00am and 6.30pm, and appointments could be made during this period on Mondays to Fridays. Appointments could be made in person at the practice reception, by phone and online through the practice website. Patients with a preference to see a specific doctor, where accommodated wherever possible. Appointments were available between 08.00am and 5.50pm on Mondays, Tuesdays, Wednesdays and Fridays; and between 07.00am and 5.50pm on Thursdays.

In addition, since October 2014, the practice had been providing a walk in appointment service during the morning surgery. The practice management team explained to us that this was in direct response to feedback from patients requesting for improved access to appointments. Patients wishing to use the walk in appointment service were required to arrive in the surgery before 10.30am.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those who were unable to attend the surgery, such as some people with long term conditions and some older people.

For families, children and young people, appointments were available outside of school hours for children and young people, and there were suitable premises for children and young people.

For working age people, there was extended opening hours. The practice had an online appointment booking system, online and telephone consultations where appropriate, and online repeats prescription request service. The practice was also planning to introduce text message reminders for appointments in the coming months.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Saturday morning clinics were started during 2014, particularly to provide seasonal flu vaccinations. The lead partner told us they were now developing a similar model for the chronic disease management.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website and in the practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice manager was the lead contact for complaints. She told us that she was also training a member of the administrative team to support her in the management of complaints.

We looked at the 18 complaints received between January and December 2014. We found that they were satisfactorily handled and that they were dealt with in a timely way.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and the key themes identified were related to staff attitudes, appointments and prescriptions system. Lessons learned from individual complaints had been acted on.

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's stated aim on their website is to provide a friendly, caring, family doctor service.

The lead practice partner also articulated the practice ethos as to reach and meet the need of their practice population, and maintain and improve on the systems that support them in achieving this.

The lead practice partner described the practice as a listening practice, and that they proactively sought and responded to feedback from their patients.

Governance arrangements

There had been a high turnover of staff, GPs and GP partners in the practice in recent years.

As a result, we found that some systems relating to patient safety had not been appropriately implemented. For example, patient monitoring, medicines management and the lead roles such as for adult safeguarding were not being properly undertaken.

In recent months, the staffing in the practice had stabilised. There was a practice manager that had been in post for the past two years however she was in post two days a week. The practice also had a deputy manager. A healthcare assistant (HCA) had recently been appointed in October 2014. Some of the HCA responsibilities included conducting annual and periodic health reviews for patients with long term conditions. These were some of the areas where the practice's performance was lower than the local and national averages, according to QOF data.

The practice had a number of policies and procedures in place to govern activity, which the practice manager told us they developed themselves and also sought support and expertise from an external company for a number of them. The practice's policies and procedures were available to staff through their electronic records system on any computer within the practice. The electronic record system had a functionality which allowed the managers to monitor who had read relevant policies and procedures. They were also able to task members of staff to read particular documents and the system flagged if this had been done. There were revision histories associated with the policies and procedures, and the ones we reviewed were all within their review date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior GP partner was the lead for safeguarding. Most aspects of leadership in the practice were undertaken by the senior GP partner with little delegation. The senior GP partner was supported by the practice manager and their deputy in leading the practice.

We spoke with eleven members of staff and they were all clear about their own roles and responsibilities, although in some cases staff had recently started taking on some additional responsibilities and were not fully familiar with those roles. Most of the staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The latest published QOF data for this practice, for the year 2013 / 14, showed it performed below the local area and national averages achieving an overall score of 76.9% which was 17.1 percentage points below CCG average, 16.6 percentage points below England average. We discussed the practice QOF performance with the lead GP during our inspection, and they cited one of the main reasons that their performance was lower was staffing changes they had experienced in recent years. We saw that QOF performance was regularly discussed at clinical meetings and action plans were produced to maintain or improve outcomes.

For the 2014 /15 year, the practice performance had significantly improved and they achieved an overall score of 98%. The practice had achieved significant improvements in the ongoing monitoring and review of its patients.

The lead GP and practice managers attended locality meetings in their clinical commissioning group (CCG). These meetings were used to discuss new developments in the local area, share best practice and compare practice performance.

Are services well-led?

Good

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

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Recent audits that were presented to us during the inspection included a Lithium audit and a prostate cancer audit.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff we spoke with told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. However the team meetings were held on a specific day in the week which meant some staff never attended as it was on a day they were not working. Minutes of the team meetings were made available to all staff via the practice's electronic records system. We reviewed the minutes of the last three staff meetings held before our inspection, and saw that a range of topics relating to practice management were discussed and the meeting was attended by many members of the staff team, including some who were not normally working during the time it was held.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the induction policy and the recruitment policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work.

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

The practice had recently started a virtual patient participation group (PPG). The practice manager told us the next stage of their involvement was to agree their terms of reference.

The practice had gathered feedback from patients through the national GP patient survey, its own practice patient surveys, comment cards and complaints received. Recent changes the practice had introduced as a result of patient feedback included a walk in appointment service.

We reviewed a report on complaints from patients received between January and December 2014. The key themes identified related to staff attitudes, appointments and the prescriptions system. Lessons learned from individual complaints had been acted on.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that annual appraisals had taken place which included a personal development plan. We also saw that staff had received role specific training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not consistently assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the regulations were not being met because there were some gaps in implementing improvements in response to incidents.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not provide care and treatment in a safe way for services users because they did not suitable arrangements in place for the proper and safe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the regulations were not being met because medicines were being issued as a repeat prescription without due checks being carried out. Some patients who were prescribed medicines with serious side effects were not monitored regularly as recommended under national guidelines. Some medicines used to treated people in medical emergencies were expired.