Dinas Lane Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report from our inspection of Dinas Lane Medical Centre. Dinas Lane Medical Centre is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 10 February 2015 at Dinas Lane Medical Centre. We reviewed information we held about the services and spoke with patients, GPs, and staff.

Overall the practice is rated as good.

Specifically, we found the practice to be outstanding for providing caring and responsive services to patients who were more vulnerable. We also found the practice to be outstanding for providing effective services for families, children and young people. It was good overall for providing effective, caring, responsive and well led services and requires improvement for providing safe services.

Our key findings were as follows:

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice promoted health education to empower patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The practice was well led. There were governance systems in place. The staff worked well together as a team and had regular staff meetings and training.

We saw several areas of outstanding practice including:

Summary of findings

- The practice had open access clinics for child care including immunisations. The uptake of all immunisations for children between 12-24 months was higher than the local averages. For example for the MMR vaccination at 24months, there was a 97% uptake compared with a local average of 95.4%.

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

The provider must:

- Carry out risk assessments for those staff working with patients who have not received a disclosure and barring services check (DBS).

The provider should:

- Carry out a legionella risk assessment.
- Carry out a control of substances hazardous to health (COSHH) risk assessment that is stipulated in the practice's health and safety policy.
- Carry out more regular fire drills and update the practice's fire risk assessment.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about patient safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe.

However, the practice were not carrying out some health and safety risk assessments including fire risk assessments and regular fire drills as required by health and safety legislation. In addition there were no risk assessments for those staff working with patients who had not received a disclosure and barring services check (DBS).

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their role and opportunities to expand their skills to the benefit of patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand the local services available. We also saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments

Summary of findings

available 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, the avoidance of unplanned admissions scheme. The practice had a designated named GP for patients who are 75 and over and care plans were in place for these patients. It was responsive to the needs of older people, and offered home visits and visits to ten nursing homes in the area by both the GPs and practice nurses. Each of the practice nurses had a protected afternoon each week to visit patients at home or in care homes to complete reviews for any long term including reviewing any medication.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There was a named GP lead for every chronic disease. The practice employed a pharmacy advisor to help carry out medication reviews and a nurse practitioner who could review patients with more complex needs. Patients with long term conditions who telephoned the surgery would be immediately triaged and signposted to the correct GP or service to ensure that their needs were assessed to prevent any deterioration in their health. All these patients had as a minimum a structured annual review to check that their health and medication needs were being met. The reviews included screening for depression.

Families, children and young people

Good

The practice is rated as outstanding for providing effective services for families, children and young people and good overall. One GP was the local safeguarding lead for the area and also the safeguarding lead for the practice. There were systems in place to identify and follow up children living in disadvantaged circumstances and also cases of domestic violence. The lead GP met with the health visitor on a monthly basis to discuss any cases.The practice had previously worked with youth groups to encourage attendance and the practice had the highest rates for chlamydia screening compared to other practices and services in the area.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this

Summary of findings

group 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 offered Saturday morning appointments in addition to weekday appointments and sent text reminders for appointments. The practice had recently introduced online prescription ordering and offered online appointment services. Telephone consultations were available instead of patients having to attend the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as outstanding for caring and responsive services to people whose circumstances may make them vulnerable and rated good overall. The practice had a lead GP for learning disabilities. On a daily basis, one GP visited a care home with approximately 50 patients who had learning disabilities. Annual health checks for people with a learning disability were carried out and health action plans updated. The practice routinely offered longer appointments for patients with learning disabilities and their carers. The practice worked with the locally commissioned Disability Co-ordinator to improve care for these patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. For example, the practice offered appointments within the practice with the Community Mental Health and Wellbeing Nurse and mental health councillors. It also arranged visits for housebound patients with mental health issues. The practice participated in enhanced services for dementia and used screening tools to identify those patients at risk.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for CQC comment cards for patients to be completed prior to our inspection.

We received 37 comment cards and spoke with three members of the Patient Participation Group (PPG). The majority of comments received indicated that patients found the reception staff helpful, caring and polite and some described their care as excellent. However, there were a few comments whereby patients were dissatisfied with being able to get through to the surgery by telephone to make an appointment at the beginning of the day.

For the surgery, our findings were in line with results received from the National GP Patient Survey. For example, the latest national GP patient survey results showed that in January 2015, 91% of patients described their overall experience of this surgery as good (from 127 responses). Eighty percent found the receptionists helpful (which is higher than the national average) but only 45% of respondents found it easy to get through to this surgery by phone compared to the Local Clinical Commissioning Group (CCG) average of **76%.**

Results from the National GP Patient Survey also showed that 91% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 100% had trust and confidence in the last GP they spoke to, which is higher than the national average.

Areas for improvement

Action the service MUST take to improve

- Carry out risk assessments for those staff working with patients who have not received a disclosure and barring services check (DBS).

Action the service SHOULD take to improve

- Carry out a legionella risk assessment.
- Carry out a control of substances hazardous to health (COSHH) risk assessment that is stipulated in the practice's health and safety policy.
- Carry out more regular fire drills and update the practice's fire risk assessment.

Outstanding practice

The practice had open access clinics for child care including immunisations. The uptake of all immunisations for children between 12-24 months was higher than the local averages. For example for the MMR vaccination at 24months, there was a 97% uptake compared with a local average of 95.4%.

Dinas Lane Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and practice manager specialist advisor.

Background to Dinas Lane Medical Centre

Dinas Lane Surgery is located in a residential area in Huyton, Merseyside, which is a deprived area of the country. There were approximately 10,000 patients registered at the practice at the time of our inspection. The practice treated all age groups but there was a larger than average proportion of elderly patients and patients in nursing homes compared to the national average.

The practice has four GP partners, four salaried GPs and a GP registrar, a nurse practitioner, two Practice Nurses, reception and administration staff and a pharmacy advisor. The practice is normally open 8.00am to 6.30pm Monday to Friday. The practice also offered Saturday morning appointments. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider (Urgent Care 24). The practice has a PMS contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes. The practice is a training practice for both GP registrars and medical students.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

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)

Detailed findings

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We carried out an announced visit on 10 February 2015.

We spoke with a range of staff including six GPs, the nurse practitioner, and practice nurses, reception staff, secretaries and administration staff, the pharmacy advisor and the practice manager on the day. We sought views from representatives of the patient participation group, nurses from two care homes, the Community Matron, the Community Mental Health and Wellbeing Nurse and looked at comment cards and reviewed survey information.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had been recording details of significant events for six years and encouraged staff to report any incidents. It included significant event protocols as part of induction training for all staff. There was a system in place for reporting and recording a broad variety of significant events which included drawing information from complaints and looking at all new cancer diagnoses. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process.

Learning and improvement from safety incidents

Staff were encouraged to complete significant event reporting forms via the practice's computer system which were then cascaded to all members of the team and the lead GP responsible for significant events. The practice held monthly 'primary health care team' meetings at which significant events arising from the month before were always discussed to identify issues and any actions required. Minutes were stored on the practice's computer system so that any staff that missed the meeting could look at the information. We viewed written minutes of these meetings which included details of the events, details of the investigations, learning outcomes and a clear action plan to prevent incidents reoccurring. We looked at incidents that had occurred and found appropriate actions had been taken and new procedures had been implemented to reduce the risk of incidents happening again. The practice had reviewed the trends in significant events. They had found occasional errors in prescribing and had therefore employed a pharmacy advisor to improve prescribing safety. They had also identified some events were around scanning and read codes for patients notes and had set up a 'data suite' which was a room specifically for use for administrators away from the main reception so they could focus on their work.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and undertook on-going audits to ensure best practice. The practice had a GP who was the prescribing lead and they liaised with the practice's pharmacist advisor on the receipt of alerts from the MHRA. Alerts were then cascaded by the prescribing lead to all clinicians. The pharmacist advisor with the help of the data administration team then searched the practice's database to identify patients who could be affected by the alert, contacted the patients and actioned any changes. The pharmacist advisor also alerted the prescribing clerks to possible queries from patients.

Reliable safety systems and processes including safeguarding

The practice had carried out audits and following toolkits recommended by professional organisations to establish systems to safeguard both adults and children from abuse. The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed above every desk area within the reception area and treatment areas. There was a GP lead for safeguarding and domestic abuse cases. There was a clear policy in place for how to handle abuse. The policy contained contact telephone numbers of any local agencies. The practice had an action plan in place to tackle cases of domestic abuse and provided patients with support information.

All staff had received safeguarding children at a level suitable to their role for child safeguarding, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. The practice kept a register of patients at risk which was reviewed monthly. The practice held internal safeguarding meetings to ensure patients were being appropriately monitored. For example, the practice held monthly primary care health team meetings with health visitors to discuss children who may be at risk.

Audits had been carried out in conjunction with the local CCG to ensure the correct safeguarding policies and procedures were in place and where shortfalls had been identified plans had been put in place. One audit had been

used as a presentation to the team and highlighted certain areas that could be improved for example linking records where there were concerns about child safety to records for any siblings.

A chaperone policy was available on the practice's computer system. The practice nurses and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff had received training but risk assessments were not in place to assess if they required a disclosure and barring check (DBS) to carry out this role.

Medicines management

The practice employed a pharmacist advisor whose role was to carry out reviews of medicines and the management of hospital discharge medicines. They also helped GPs with any queries regarding drug interactions and helped with any MHRA alerts affecting patient's medication which contributed to the safety of prescribing. The practice had an electronic prescribing system but occasionally also used paper prescriptions; these were securely stored and managed.. In addition, one of the GPs who was the prescribing lead regularly reviewed any alerts or guidelines and information was regularly updated on the practice's computer systems for patients to access. Any changes were cascaded to staff via email alerts.

The practice also had regular meetings with the pharmacy support team from the local CCG.

The practice had two fridges for the storage of vaccines. The practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the reception area for easy access. The nurse practitioner had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

Cleanliness and infection control

All areas within the practice were found to be clean and tidy. The practice manager carried out monitoring checks to ensure the practice cleanliness was acceptable. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and a spillage kit was available.

One of the practice nurses was the designated clinical lead for infection control and had received training suitable for this role. They attended community infection control meetings and cascaded information from these meetings back to the practice. All staff received infection control training and there were policies and procedures in place which were easily accessible for all staff on the practice's computer system. Regular audits were carried out and acted on; the last one was December 2014 which scored 96% compliance.

Equipment

The practice manager ensured all electrical equipment had received a portable appliance check to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

The nurse practitioner carried out monthly checks on emergency equipment such as the oxygen and defibrillator.

Staffing and recruitment

The practice had four GP partners, four salaried GPs and a GP registrar, a nurse practitioner and two practice nurses. The clinical members of staff were supported by reception, secretaries and administration staff and a practice manager. Staff felt there were enough staff to meet the needs of patients and covered each other in the event of unplanned absences. The practice had systems in place to actively manage the GP and nurse rota so that safe levels of staffing were in place.

Requires improvement

Are services safe?

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had a new employee checklist to ensure all relevant documentation and processes were carried out including proof of identification as well as ensuring staff received information regarding confidentiality and health and safety. We looked at recruitment documentation files which were well organised and found necessary pre-employment checks had been carried out. The practice also checked the annual professional registration status for nurses. Some staff acted as chaperones but there were no risk assessments in place to ascertain whether they required further employment checks.

Monitoring safety and responding to risk

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff. Part of this policy was to have a control of substances hazardous to health (COSHH) risk assessment in place however this had not been completed. The practice had not carried out a legionella risk assessment.

The practice had been refurbished in 2009 and the fire risk assessment had been updated at this point however needed to be updated further to record the number of staff working on the upper floors of the building and to assess the storage of flammable substances. The practice had previously carried out fire drills but this had not been for several years but staff were aware of what to do in the event of fire.

The practice had taken part in an audit in conjunction with the local CCG to which demonstrated that it was following best practice guidelines for the cold chain storage of vaccines and use of emergency medicines.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the reception area. There were also quick reference guides for administration of adrenalin for the treatment of anaphylaxis. The practice had oxygen and a defibrillator available on the premises. The practice had recently taken part in an audit with the local CCG to ensure that they were following best practice guidelines for the types of emergency medicines required. There was a first aid kit and accident book available.

We discussed medical emergencies with practice nurses and one gave an example of an emergency that had happened previously which was dealt with appropriately. The practice held a meeting to discuss the incident, what actions were taken and what could be learnt from this. It was recognised that if the emergency had occurred a few minutes earlier there may not have been a clinician available and as a consequence, the nurse practitioner had altered her working hours to improve upon the safety of the practice.

The practice had a comprehensive disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found some staff were aware of the practicalities of what they should do if faced with a major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the practice nurses carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. The practice nurses referred the patient to the GP when necessary.

The practice employed a nurse practitioner who assisted in telephone triage of patients to ensure patients were directed to the most appropriate service within the practice.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The lead for clinical governance ensured all staff received e-mails regarding any changes to National Institute for Health and Care excellence (NICE) guidance.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. In addition all new cancer diagnoses were flagged up and an email was sent to all clinicians to advise them. All new cancer diagnoses were listed as significant events so the whole clinical team could discuss and make appropriate arrangements for care.

There were a number of effective assessment systems in place. For example, elderly patients who had any fractured bones were screened and assessed for osteoporosis; patients with long term health conditions were screened for depression at their review appointments. Patients on anticoagulant therapies had their bloods monitored at the practice so that all their needs could be assessed in house.

The practice took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at monthly primary health care team meetings and ensured care plans were in place and regularly reviewed.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The entire practice team were involved in driving improvements forward. One of the GP partners was the lead for QOF, the annual changes to QOF and each of the GPs acted as a clinical lead in specific chronic disease areas in QOF. The Nurse Practitioner led to ensure that the practice met all its contractual requirements and to consistently improve the performance.

The practice was aware of its Intelligent Monitoring banding score and the only elevated risk was around podiatry for diabetes management. One of the GPs was the chair of the local CCG and was aware there was a possible issue with referring patients in the area to podiatry services and the CCG were looking into this matter.

All GPs and nursing staff were involved in clinical audits. Examples of audits included antibiotic and antidepressant prescribing. Audits were regularly redone and we could see improvements over time. Learning points from clinical audits were routinely discussed at staff meetings by means of presentations and were also kept on the practice's computer system.

The practice had reviewed trends in significant events and had identified prescribing errors as a key area for improvement in clinical safety. As a result of this the practice had then employed a pharmacy advisor to oversee all medication reviews and medications for patients after discharge from hospital to ensure risks around prescribing medications were reduced.

The practice also met with the local (CCG) to discuss performance. The practice held a Personal Medical Services (PMS plus) contract whereby the practice was awarded for improving outcomes for example increasing the uptake of screening for various cancers and immunisation rates. The practice performance overall was in the highest bracket for this contract. The practice had action plans in place and named members of staff to follow up patients who did not attend appointments for screening.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

All staff received training that included: - safeguarding vulnerable children, basic life support, information

Good

Are services effective?

(for example, treatment is effective)

governance awareness and infection control. The practice was closed for half a day a month to accommodate training that was organised by the local CCG. The practice manager attended local forums with managers from other practices in the area.

The practice employed a nurse practitioner whose main roles were clinical triage, leadership for nurses in the practice and quality improvement for QOF and the PMS contract. The nurse practitioner acted as the clinical and managerial lead for the practice nurses and carried out their appraisals and organised two practice nurse meetings per month.

The practice nurses attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurses were given protected learning time and supported to attend meetings and events outside of their normal working hours.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (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)

The practice was a training practice and there was a lead for GP training and a lead for teaching medical students. All GPs at the practice were involved in the GP trainee programme. We saw evaluation reports of the training received by medical students who on the whole rated their training as very good.

All staff were given opportunities to expand their roles. For example five administrators had been trained to take bloods. Some staff had received carers awareness training, smoking cessation training and chaperone training.

There were appraisal systems in place. The practice manager oversaw the appraisals of all non- clinical staff.

Working with colleagues and other services

Incoming referral letters requiring action were immediately passed to the GP prior to scanning the information onto the patient's notes. The practice had one member of staff who specifically dealt with the scanning of letters to avoid backlogs and ensure the GPs were kept up to date with patient information. The practice had access to patients' tests results and had a system in place for recording information on to patients' medical records. Cases which required immediate follow up were flagged up on the practice's computer task system for the GP to action. Each GP could access their patients' follow up requirements. Urgent information was given directly to the GP. Patients were contacted as soon as possible if they required further treatment or tests.

Patients were referred to hospital using the 'Patient Choose and Book' system and used the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral. Regular audits of the system were carried out to ensure there were no delayed diagnoses and to ascertain if any improvements could be made.

The practice liaised with other healthcare professionals such as the Community Diabetic Specialist, the Community Matron and the Community Mental health and Wellbeing Nurse.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. There were clear guidelines for staff regarding information governance and the sharing of information displayed in the reception offices. Individual clinical cases were analysed at a team meeting as necessary. For example, the practice in conjunction with community nurses and matrons held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care at the start of their monthly primary health care team meetings and minutes of these meetings were available to all staff involved. The practice had up to 70 patients on the GSF list. All of the patients on the list had a named GP. Each patient's needs were discussed at these meetings and then decisions reached as to whether the patient should be reviewed and any actions that need to be taken and by whom.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice liaised with the out of hours provider regarding any special needs for a patient; for example e-mails were sent regarding end of life patients.

Good

Are services effective?

(for example, treatment is effective)

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer.

Consent to care and treatment

The practice had a Mental Capacity Act policy in place, practice guides and forms to help GPs with determining mental capacity of patients. We spoke with the GPs about their understanding of the Mental Capacity Act 2005. They provided us with examples of cases where best interest meetings had been held that demonstrated their understanding around consent and mental capacity issues. We spoke with nurses from local care homes with patients registered with the practice who told us that the GP would often follow up the following day to check the patient had remembered and understood the treatment needed. The practice also had access to advocates when necessary.

The GPs were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice carried out joint injections and we found appropriate information and consent forms for patients were in place.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations.

The practice nurses held clinics for a variety of chronic diseases such as diabetes and chronic obstructive pulmonary disease.

The practice recognised the high prevalence of chronic obstructive pulmonary disease in the area and had a smoking cessation service. Two members of staff had been trained at the Roy Castle Lung Foundation to support smoking cessation for patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP patient survey (from 127 responses) also showed that 91% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 97% said the last GP they saw or spoke to was good at listening to them which is higher than the national averages.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 93% said the last GP they saw or spoke to was good at explaining tests and treatments and 92% said the last GP they saw or spoke to was good at involving them in decisions about their care which was higher than the national average . Eighty eight percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was higher than the local average.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. The practice also ensured that all bereaved relatives were contacted and sent condolence cards to bereaved relatives. Staff from local care homes we spoke with told us how GPs could often visit the care homes more than once in the same day and always spent time with patients who were on end of life care.

There was supporting information to help patients who were carers. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support. Some staff had received carers awareness training.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available in the waiting room and on the practice's website. The PPG met quarterly and patient surveys were sent out annually.

We spoke with three members of the group who told us the practice management had been responsive to any of their concerns. For example, the practice in response to patient's comments had put on display at the entrance of the practice two large plaques which displayed information about all the staff that worked at the practice and the variety of clinics available.

The practice had initiated positive service improvements for its patients. The practice had reviewed trends in significant events and had identified prescribing errors as a key area for improvement in clinical safety. As a result of this the practice had then employed a pharmacy advisor to oversee all medication reviews and medications for patients after discharge from hospital to ensure risks around prescribing medications were reduced.

All staff were engaged in ensuring patients could access screening services and the practice had the highest rates for chlamydia screening compared to other practices and services in the area. Clinicians were involved in carrying out falls audits in conjunction with the local community falls and wellbeing service for elderly patients to identify those patients who may require additional medication or help and had significantly reduced the number of falls and increased correct medication uptakes.

The practice had systems to ensure appropriate timely referrals for urgent cases. All new cancer diagnoses were flagged up and an email was sent to all clinicians to advise them. All new cancer diagnoses were listed as significant events so the whole clinical team could discuss and make appropriate arrangements for care.

Tackling inequity and promoting equality

The practice had a small proportion of minority groups for whom English was not their first language but it always recorded patient's language and ethnicity at registration.

The practice had identified languages that their patient population mainly spoke and had altered its automated check in screen in the waiting room so that these patients could use this service.

The surgery had access to translation and also sign language services. One of the GPs could use sign language. A hearing loop was available. Staff could give examples of how they had treated patients with hearing difficulties appropriately.

The building had appropriate access for disabled people. The practice took into consideration the needs of nursing mothers and had previously won a breast feeding award.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

Access to the service

The practice was open between 8.00am to 6.30pm Monday to Friday and Saturday mornings for appointments with the nurses or GP. The practice had extended its Saturday opening times for flu vaccinations until 6pm to meet the needs of the working population of patients in particular. Patients could make appointments either by telephone or by visiting the practice. Seventy five per cent of appointments were booked on the day and pre bookable appointments could be made up to four weeks in advance.

The practice had open access systems in place for phlebotomy. The practice had five members of the administration team who had been trained to take bloods. The practice used the skills of the staff to operate an open access appointment for patients to have routine bloods done at any time of day. This service benefited all patients by avoiding having to book for tests elsewhere and they could access the service at a time that suited them. Patients who required blood tests due to taking anti-coagulant medication were also tested within the practice by the nurses so that all results were kept in house without the need for the patient to visit another service.

The practice had open access systems in place for child care. This included children's vaccinations which could either be pre-booked or done opportunistically if the child came in at any time.

The practice provided care for 10 care homes in the area including a care home for patients with learning disabilities. We were told a total of 920 visits were carried

Good

Are services responsive to people's needs?

(for example, to feedback?)

out for care homes in the preceding year. We spoke with nurses from two different care homes who told us that the GPs could often visit the same person more than once during the day and that the nurse practitioner and GPs were very good at dealing with any enquiries they had. They told us about circumstances were they had needed prescriptions urgently and the GPs had visited after surgery hours to deliver the medicines. Home visits were also carried out and the practice placed an emphasis on seeing patients at the right time and in the right place. The nurses also carried out home visits to housebound and nursing home patients.

Listening and learning from concerns and complaints

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

Information about how to make a complaint was available on the practice's website and in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

Learning points from complaints were discussed at staff meetings and all patients were written to with an explanation and apology when things had gone wrong.

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

According to the practice's website the practice aimed to provide the highest standard of healthcare with the help of its patients. Staff we spoke with were aware of the culture and values of the practice and described the practice as forward thinking and maintaining the compassionate values of a family practice. Comments we received were very complimentary of the standard of care received at the practice.

The practice held business meetings twice a year to forward plan its services. The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

The practice looked at their quality of healthcare under six dimensions of quality: safety, effectiveness, patient centred, timely, equitable and efficient. The practice could identify its strengths, weaknesses and opportunities such as employing a health care assistant in the future.

The practice had action plans in place and named members of staff to assist with forward plans. For example, to help increase screening uptakes for various diseases.

Governance arrangements

There was a strong emphasis on clinical governance with one of the GP partners being the lead. The practice had a clinical governance policy in place. The governance policy covered: patient involvement, clinical audit, staffing, and education and risk assessments.

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All the policies appeared to be in date but some like the Health and Safety needed to be reviewed to ensure aspects of the policy were being fully implemented.

All staff were involved and encouraged to drive improvements by engaging in audit work and significant events analysis. The practice had a rolling audit system in place for many aspects of patient care including medicines and safeguarding. The practice monitored its effectiveness of patient journey and experience from being contacted by practice, to having reviews completed including medicine reviews, initiating any necessary clinical changes needed, patient notes coded correctly and setting up any recalls needed. The audits and results were shared during presentations at staff meetings.

Leadership, openness and transparency

Staff had specific roles within the practice for example all GPs had lead roles for the various chronic conditions and additional roles included safeguarding, prescribing and infection control.

Staff we spoke with told us they were well supported in their roles. For example, the GPs operated a system of time slots being available within the day so that other clinicians could discuss any concerns about patient case management.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

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

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with three members of the PPG who told us The PPG felt that the practice was responsive to any issues raised by the group.

The practice was aware of feedback from NHS choices and patient surveys that telephone access to make appointments first thing in the morning could be improved. The practice told us they were introducing a new telephone queuing system to try and tackle this problem.

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. Initial feedback had been positive with 93% of patients recommending the service to their friends or family.

Management lead through learning and improvement

Are services well-led?

Good

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

The practice placed a strong emphasis on continuous professional development for all staff. The practice was a training practice for GPs and medical students and the feedback from participants was positive.

The practice worked well together as a team and held regular meetings for team learning and to share information. For example, the practice held monthly primary care health team meetings attended by the GPs, practice nurses, nurse practitioner, practice manager, administration staff, district nurses, the Community Matron, and McMillan nurses. Sometimes the practice invited a guest speaker at the beginning of a meeting. The meeting then discussed each patient on the Gold Standards Framework (GSF) register patients in turn. The practice discussed significant events from the previous month, and together agreed an action plan for each. An update on any current safeguarding issues, unplanned admissions, screening issues and new cancer diagnoses and deaths were also discussed.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and ensured the whole team was involved in driving forward improvements. They recognised future challenges and areas for improvement.

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the provider had not carried out risk assessments for staff who worked with patients and did not have a DBS check in place. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.