Brigstock 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

We carried out an announced comprehensive inspection at Brigstock and South Norwood Partnership on 26 October 2016. Overall the practice is rated as requires improvement.

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

- The practice had systems in place to keep patients safe and safeguarded from abuse, but these were not sufficiently well embedded. Some clinical staff had not received training in safeguarding adults, or recent training in child safeguarding. The non-clinical staff had not undertaken safeguarding training and some of them we spoke to were not very confident in their understanding of behaviour that might indicate a safeguarding issue, although they were aware of their responsibilities if they were concerned about a patient. Non-clinical staff were not trained to act as chaperones, and did not do so, but some of those we spoke to said they thought they might be a chaperone if a nurse or healthcare assistant were not available.
- There were areas of risk that had not been effectively assessed and addressed, such as electrical testing and arrangements for medical emergencies. Not all clinical staff had had recent basic life support training. There was no defibrillator, and the practice had not carried out a risk assessment to support the decision not to acquire one.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was generally well equipped to treat patients and meet their needs, although there was no defibrillator.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider **must** make improvement are:

- Ensure there are adequate arrangements to manage medical emergencies; either obtain a defibrillator or complete a risk assessment which mitigates the risks of not having one.
- Ensure that staff receive the training required for their role at the expected frequency (including safeguarding, information governance and role-specific training); ensuring that training within the practice covers the required topics at the appropriate level for the role, and that all clinical staff complete annual basic life support training for clinical staff. Arrange annual basic life support training for non-clinical staff (in line with current guidance).
- Advertise the chaperone service and ensure that staff are clear who can and cannot act as a chaperone.
- Ensure all staff have up to date training in safeguarding adults and children, and are confident in their understanding of behaviour that might indicate a safeguarding issue.

The areas where the provider should make improvement are:

- Risk assess portable electrical appliance testing arrangements.
- Review infection prevention and control leadership and audit arrangements, to ensure that all risks are being identified and acted upon.
- Continue to monitor (and where appropriate act upon) patient satisfaction with the telephone and appointment systems.
- Consider providing written information for carers about local support services.

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.

- The practice had some systems in place to keep patients safe and safeguarded from abuse, but these were not sufficiently well embedded. Some clinical staff had not received training in safeguarding adults, or recent update training in child safeguarding. Some of the non-clinical staff members we spoke to were not very confident in their understanding of behaviour that might indicate a safeguarding issue, although they were aware of their responsibilities if they were concerned about a patient.
- Non-clinical staff were not trained to act as chaperones, and did not do so, but some of those we spoke to said they thought they might be a chaperone if a nurse or healthcare assistant were not available.
- Most risks to patients were assessed and well managed; however, there were areas of risk that had not been effectively assessed and addressed, such as electrical testing and arrangements for medical emergencies. Not all clinical staff had had recent basic life support training. There was no defibrillator, and the practice had not carried out a risk assessment to support the decision not to have one.
- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- There was no training policy or effective arrangements to ensure that all staff had completed the required training at the expected frequencies.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments 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 evidence showed the practice responded quickly to issues 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.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- Practice specific policies were in place, but were not all implemented effectively, since there were areas of which staff were not clear, for example, the practice chaperoning policy.
- There were some arrangements for managing risks, but these had not identified the risks associated with the lack of a defibrillator and incomplete basic life support training.
- Infection prevention and control arrangements had failed to identify the risks associated with a clinical samples bin placed at a height that young children could access in the waiting room.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was improvement activity, and the practice had previously won external awards and accreditation.

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.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Older patients had a named GP to support their care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable to the national average. For example, 70% of patients with diabetes, had their HbA1c (blood sugar over time) last measured at 64 mmol/mol or less, compared to the local average of 72% and the national average of 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

- The practice's uptake for the cervical screening programme was 84%, which was comparable to the CCG average of 82% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

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 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 age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Some clinical staff had not received training in safeguarding adults, or recent update training in child safeguarding. Some of the non-clinical staff members we spoke to were not very confident in their understanding of behaviour that might indicate a safeguarding issue, although they were aware of their responsibilities if they were concerned about a patient.

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).

Summary of findings

- 89% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average/ worse than the national average.
- Performance for mental health related indicators was comparable to the national average. For example, 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan, compared to the local average of 85% and the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. Three hundred and sixty survey forms were distributed and 95 were returned. This represented under 1%of the practice's patient list. The results showed the practice was performing in line with local and national averages.

- 74% of patients found it easy to get through to this practice by phone compared to the local average of 74% and the national average of 73%.
- 79% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 75% and national average of 76%.
- 83% of patients described the overall experience of this GP practice as good compared to the local average of 82% and the national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 77% and national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards. Twenty six cards were wholly positive about the standard of care received. Ten cards were generally positive but with some negative comments, and one card was solely negative. Five negative comments were about difficulties getting through to the practice by telephone. Other negative comments were about having to wait after appointment time, and the practice appointment system (not being able to make an appointment in advance and speaking to the GP by telephone rather than face-to-face).

We spoke with nine patients during the inspection. All nine patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Brigstock Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Brigstock Medical Centre

Brigstock and South Norwood Partnership has nearly 17,000 patients and is in Croydon, south London. The surgery is purpose built premises, over two floors. The building has disabled access, toilet facilities and a recently installed lift. There is no dedicated parking for the practice, but cars can park on nearby side streets The area is well served by public transport.

Compared to the England average, the practice has more young children as patients (age up to nine) and fewer older children (age 10 – 19). There are more patients aged 20 – 49, and many fewer patients aged 50+ than at an average GP practice in England. The surgery is based in an area with a deprivation score of four out of 10 (a score of one being the most deprived), and has a higher level of income deprivation affecting older people and children. Compared to the English average, more patients are unemployed.

Six doctors work at the practice: four male and two female. Four of the doctors are partners, with a pharmacist partner, and there are two salaried GPs (one male and one female). Some of the GPs work part-time. The combined GP working hours are the equivalent of five full-time GPs.

The (all female) nursing team is made up of a nurse prescriber, three practice nurses and three health care assistants.

In addition to the pharmacist partner, there is also a salaried pharmacist.

Brigstock and South Norwood Partnership is a merger of two older practices, Brigstock Medical Practice and South Norwood Medical Centre. The merger took effect on the 10 August 2015 and the staff of the South Norwood Medical Centre moved into the former Brigstock Medical Practice building. There is also a cosmetic laser treatment clinic based within the practice, run by the partners, but with separate treatment and reception rooms.

The practice trains junior doctors as GPs, and takes medical students, student nurses and physician associates for placements.

The practice is open 8am to 6.30pm Monday to Friday. Extended hours appointments are available with doctors and nurses from 6.30pm to 8.30pm, on Tuesday, Wednesday and Thursday.

When the practice is closed cover is provided by a local service that provides out-of-hours care.

The practice offers GP services under a Personal Medical Services contract in the Croydon Clinical Commissioning Group area. The practice is registered with the CQC to provide family planning, surgical procedures, diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services.

This is the first time that the CQC has inspected the practice.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on Wednesday 26 October 2016.

During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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).

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, after a patient came to harm because their address was not updated, meaning that they did not get their medicines, the issue was discussed with staff to ensure they all understood the importance of timely changes.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse, but these were not well-embedded. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Clinical staff had all received training on safeguarding children and most had received training on vulnerable adults relevant to their role (although not all as recently as would be expected) and demonstrated that they understood their responsibilities. GPs were trained to child protection or child safeguarding level 3, nurses, pharmacists and healthcare assistants to level 2. We checked five staff files and found two members of clinical staff who had not received child safe guarding for several years (since 2011 and 2012) and who had not had any training in safeguarding adults. Non-clinical staff had not had formal training in child safeguarding, and some we spoke to were not very confident in their understanding of behaviour that might indicate a safeguarding issue, although they were aware of their responsibilities if they were concerned about a patient.
- The practice provided chaperones, but there were no notices advising patients that chaperones were available. Only clinical staff acted as chaperones. These staff had received a Disclosure and Barring Service (DBS) check for their clinical role. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We asked non-clinical staff about chaperoning. All were clear that this role was performed by nurses and health care assistants. No non-clinical member of staff recalled acting as a chaperone in the last few years, but they were not clear that the practice policy was that they were not to act as chaperones and more than one member of non-clinical staff said that they thought they might be a chaperone if a nurse or healthcare assistant were not available.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. There was an infection control protocol in place. The practice nurse who was the infection control lead had received specialist training for the role, and received update training in 2014. Other staff members told us that they had received training from the practice nurse, and could give examples of how they acted to help prevent and control infection. We identified one potential infection control risk during the inspection: a small domestic

swing-top bin for patients to put samples (for example, of urine) was on the floor in a corner of reception area, where it was accessible to children, but out-of-sight of reception staff. We raised this with the practice and the samples bin was moved to behind the reception desk.

- There were arrangements for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal) to keep patients safe.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored upon arrival in the practice and there were systems in place to monitor their use. Serial numbers of blank prescription forms were recorded when they were taken into clinical rooms in put into printers, but they were not removed at night. The doors of clinical rooms were locked during the day when not in use, but cleaning staff had access to the rooms at night.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) Health Care Assistants were trained to administer vaccines and medicines against either a patient specific prescription or a patient specific direction (PSD) from a prescriber. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.)
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Most risks to patients were assessed and generally well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. Clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Electrical equipment had last been checked to ensure that it was safe to use in 2014. Practice staff said that they had been advised (verbally) that testing was required only every three years, and so testing had not been repeated since 2014. This guidance had not been confirmed elsewhere and the decision not to carry out testing had not been risk assessed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents, but did not have all that we would expect to support patients in a medical emergency.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice provided annual basic life support training, which most clinical and non-clinical staff had attended.
- The practice had oxygen with adult and children's masks. A first aid kit and accident book were available. There was no defibrillator available in the premises, and the practice had not carried out a risk assessment to support the decision not to acquire one.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

Requires improvement

Are services safe?

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

The most recent published results (2014/15) were 97% of the total number of points available, compared to the local average of 94% and the national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

Performance for diabetes related indicators was comparable to the national average.

- 70% of patients with diabetes, had their HbA1c (blood sugar over time) last measured at 64 mmol/mol or less, compared to the local average of 72% and the national average of 78%.
- 91% of patients with diabetes had well controlled blood pressure, compared to the local average of 78% and the national average of 78%.
- 96% of patients with diabetes had an influenza immunisation, compared to the local average of 90% and the national average of 94%.
- 80% of patients with diabetes had well controlled total cholesterol, compared to the local average of 76% and the national average of 81%.
- 96% of patients with diabetes had a foot examination and risk classification, compared to the local average of 87% and the national average of 88%.

Performance for mental health related indicators was comparable to the national average.

- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan, compared to the local average of 85% and the national average of 88%.
- 97% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded, compared to the local average of 88% and the national average of 90%.
- 88% of patients diagnosed with dementia had a face-to-face review of their care, compared to the local average of 85% and the national average of 84%.
- 93% of patients with physical and/or mental health conditions had their smoking status recorded, compared to the local average of 94% and the national average of 94%.

Rates of exception reporting were also similar to local and national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Evidence from the practice indicated similar QOF results for 2015/16.

There was evidence of quality improvement including clinical audit.

- In addition to prescribing audits suggested by the CCG, there had been five clinical audits carried out in the last two years, one of these was a completed audit where the improvements made were implemented and monitored. The completed audit was a review of patients prescribed high dose simvastatin (a medicine used to treat high cholesterol) with certain calcium channel blockers (used to treat conditions of the heart and blood vessels), prompted by guidance that said that these combinations could have serious side effects. The practice found 239 patients prescribed simvastatin and one of the calcium channel blockers, of whom 176 were being prescribed simvastatin at a high dose, meaning that only 26% of patients were being prescribed the

Good

Are services effective?

(for example, treatment is effective)

medicines at the recommended dose. The practice took various actions to change their prescribing, including writing to patients, training administrative staff to highlight relevant prescription requests to clinicians and liaison with the local pharmacy. When the audit was repeated, there were 247 patients taking simvastatin and one of the calcium channel blockers, of whom 12 were being prescribed simvastatin at a high dose, meaning that 95% of patients were being prescribed the medicines at the recommended dose.

- The practice participated in research, for example a study looking at the effectiveness of practice testing to assess whether patients with chronic obstructive pulmonary disease (COPD)require antibiotics.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- All staff had received an appraisal within the last 12 months.
- There was no policy that specified what training was required for each role, and at what frequency. Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance, but training was not being completed by all staff at the frequency recommended by published guidance (in the case of safeguarding and basic life support). Not all staff had completed information governance training, but partners told us that potential issues were often discussed, since the practice is involved in research. GPs received training on many subjects off-site, with other GPs from the clinical commissioning group, and there were no formal mechanisms to ensure that the training (on subjects like the Mental Capacity Act) was cascaded to other clinical staff (or was covered by another mechanism).
- Clinical staff were responsible for planning their own role-specific training, to ensure that this was up-to-date. Training was one element reviewed in appraisal. We saw evidence of recent specialist training for staff caring for staff with long-term conditions.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- GPs had received training on the Mental Capacity Act 2005. Other staff had not had formal training, but those we spoke to were able to give an explanation of legislation.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

Good

Are services effective?

(for example, treatment is effective)

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care and carers.

Patients were referred to dieticians when required, and smoking cessation advice was available from a local pharmacy.

The practice had adopted innovative models to support patients to improve their own health, for example, peer supporters and group consultations for patients with diabetes.

The practice's uptake for the cervical screening programme was 84%, which was comparable to the Clinical Commissioning Group (CCG) average of 82% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Uptake by patients at the practice was in line with local averages,

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 91% to 98% (local rates ranged from 85% to 93%) and five year olds from 80% to 96% (local rates ranged from 73% to 92%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards. Twenty six cards were wholly positive about the standard of care received. Ten cards were generally positive but with some negative comments, and one card was solely negative. Five negative comments were about difficulties getting through to the practice by telephone. Other negative comments were about having to wait after appointment time, and the practice appointment system (not being able to make an appointment in advance and speaking to the GP by telephone rather than face-to-face).

We spoke with nine patients during the inspection. All nine patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was generally in line with average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%
- 77% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82% and the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 81% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

Good

Are services caring?

The practice provided facilities to help patients be involved in decisions about their care. For example, staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 318 patients as carers (2% of the practice list). Staff told us that GPs and nurses would provide support to individual patients as required, but there was no written available for staff to give to carers, about the avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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. For example, the practice had arranged with the CCG to offer minor surgery, so that patients could receive this service without having to travel to hospital.

- The practice offered evening appointments with doctors and nurses from 6.30pm to 8.30pm, on Tuesday, Wednesday and Thursday for working patients who could not attend during normal opening hours. These were only available to book online.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice was accessible to people who use a wheelchair and there was a hearing loop and translation services available.
- The practice had recently fitted a lift to improve access.
- Welfare benefit advisors and counsellors attended the practice to support patients.

Access to the service

The practice was open 8am to 6.30pm Monday to Friday. Extended hours appointments were available with doctors and nurses from 6.30pm to 8.30pm, on Tuesday, Wednesday and Thursday.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the local average of 75% and the national average of 76%.
- 74% of patients said they could get through easily to the practice by phone compared to the local average of 73% and the national average of 73%.

Four of the nine patients we spoke to, and six of the 26 comment cards we received, said that getting through on the telephone could be difficult. In response to previous complaints about telephone access the practice had increased the number of phone lines (from four to 10) and arranged more staff to be available to answer incoming calls. Staff told us that they were aware that patients sometimes found the phone system busy. Further work had been considered to increase phone capacity, but would require considerable investment, so had not been taken forward.

The practice operated what they call a 'doctor first' system, where all patients who request a consultation with a doctor receive a telephone consultation. Doctors then decide, with the patient, whether the patient needs a face to face consultation.

Other than the extended hours appointments in the late evening (which were bookable only online), there was no mechanism to book routine GP appointments in advance, unless specifically authorised by a GP.

Staff told us that this appointment system had been introduced following an internal review, and that they believed that it was one of the factors that had led to a reduction in A&E attendances by patients from the practice. Most patients that we spoke to were happy with the appointment system, although some said they would prefer a more traditional arrangement with face-to-face consultations. One patient said that they were frustrated by being unable to pre-book an appointment, even when a GP had said it was necessary.

GPs called patients requesting a home visit to assess whether a home visit was clinically necessary, and the urgency of the need for medical attention. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available in reception and on the practice website to help patients understand the complaints system.

We looked at two of the complaints received in the last 12 months and found that these were satisfactorily handled; dealt with in a timely way, and with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, following a pattern of complaints, the practice added resources to improve telephone capacity.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values.

Governance arrangements

- There was a clear staffing structure.
- Practice specific policies were in place, but were not all implemented effectively, since there were areas of which staff were not clear, for example, the practice chaperoning policy.
- There was no training policy or effective arrangements to ensure that all staff had completed the required training at the expected frequencies.
- There were arrangements for managing risks, but these had not identified the risks associated with the lack of a defibrillator and incomplete basic life support training.
- Infection prevention and control arrangements had failed to identify the risks associated with a clinical samples bin placed at a height that young children could access in the waiting room.
- Clinical and internal audit was used to monitor quality and to make improvements.

Leadership and culture

Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and discussed proposals for improvements with the practice management team.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, innovative models to support patients to improve their own health, for example, peer supporters and group consultations for patients with diabetes.

The practice achieved Investors in People accreditation from 2011 onward, and a Royal College of General Practice Quality Practice Award in 2013.

Are services well-led?

Good

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

The practice had successfully bid for funds to improve the practice premises in 2012 and 2015.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. They had failed to identify the risks associated with: • Not all clinical or non-clinical staff had completed basic life support training • A clinical samples bin was stored at floor level in reception • No defibrillator on the premises, which had not been formally risk assessed • Chaperone service was not being advertised. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Some clinical staff had not received training in safeguarding adults, or recent training in child safeguarding. The non-clinical staff had not undertaken safeguarding training and some of them we spoke to were not very confident in their understanding of behaviour that might indicate a safeguarding issue, although they were aware of their responsibilities if they were concerned about a patient.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 13(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.