Marlborough Street Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Marlborough Street Surgery on 15 October 2014. Marlborough Street Surgery at 1 Marlborough Street, Devonport Plymouth PL1 4AE provides primary medical services to people living in the Devonport area in the city of Plymouth, Devon and there is also a branch surgery called Glendower in the Peverell area of the city. Both practices provide services to a diverse population and age group.

The practice was rated as Requiring Improvement

Our key findings were as follows:

Patient feedback from surveys, comment cards and verbal feedback was overall positive. The majority of patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The practice enabled patients to book appointments quickly.

There were concerns regarding the monitoring of infection control and staff knowledge of safeguarding adults and children. GPs had received safeguarding training at the appropriate level. Training was not monitored adequately and some staff did not receive all the training they needed to help them provide safe and effective care.

The practice undertook audits and reviewed any serious incidents that occurred, however we could not see evidence that all staff were made aware of any changes that had been made to improve the service.

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

Importantly, the provider must:

- All staff, according to their job role, must receive training updated training in safeguarding vulnerable adults and children.
- If reception staff are used as chaperones they must have received training to undertake this role.

In addition the provider should:

Summary of findings

Clinical Governance meetings should be held more frequently and a means of relaying any discussion and/or remedial actions to all staff should be introduced and formalised.

A risk assessment regarding Legionella testing should be carried out.

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 safe and improvements must be made. Staff were aware of their responsibilities for reporting incidents, near misses and concerns. However, when things went wrong reviews were undertaken but lessons learnt were not communicated in order to improve safety.

The practice did not ensure that staff had an understanding of safeguarding vulnerable patients. We were told that training in this area had been undertaken by staff during a clinical governance meeting but some staff could not recall this. Staff received some training appropriate to their roles but further training needs were identified, including awareness of the Mental Capacity Act 2005 and safeguarding of vulnerable adults and children . No formal records of training being undertaken were kept. We were told by the practice manager that all new staff took an on line course as part of their induction.

The practice was visibly clean. We were told by staff that infection control checks were carried out to support that infection control measures that were in place to protect patients from the risk of infection in treatment rooms.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a service to patients. Staff received the necessary training and development for their role. There was a proactive approach to using data to analyse and improve outcomes for patients. There had been clinical audits, which had resulted in improvements to patient care and treatment. There were robust recruitment procedures in place.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect. However, conversations between the GP and patients could be heard outside the consulting room so confidentiality was not always maintained.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The GP consulting rooms were all situated on the first floor of the practice with the treatment rooms on the ground floor. There was a staircase to the first floor, if patients could not use the stairs this was identified when making the appointment and a room or treatment room was made available for a GP consultation on the ground floor.

A range of clinics and services were offered to patients, which included child immunisation and nurse specialist clinics for long-term conditions. Interpreters were used for patients who did not speak English. Patients we spoke with told us appointments were easy to arrange. They told us they were able to obtain urgent appointments on the same day. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised.

Are services well-led?

Requires improvement

The practice is rated requires improvement for being well led. There was a clear vision and strategy aimed at delivering quality care and treatment. Junior staff reported an open culture and told us they could communicate with senior staff. They felt supported by management. The practice had a number of policies and procedures in place to govern activity, these were on the intranet but staff we spoke with were not aware of them. We found some learning from significant events had not been communicated to staff and there were examples where this could impact on safety. There were systems to discuss incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff, however the outcomes from these meetings were not relayed back to all staff.

The practice previously had a patient participation group (PPG) but this dissolved through lack of membership. The practice had been unable to establish a patient participation group for the past two to three years, so proactively sought feedback from staff and patients through the use of an external survey company.

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 patients. The practice provided good quality care to older patients. Patients over 75 years old had a named GP to provide continuity in care. Health checks and promotion of healthy lifestyles were encouraged and offered to this group of patients. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older patients during routine appointments or by arrangements with the healthcare workers. GPs undertook home visits for older patients who lived in local care homes or who were housebound and had difficulty visiting the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered for specific conditions such as diabetes and asthma. Although the practice did not provide named GPs for patients with chronic medical conditions, patients felt well cared for and said they could access appointments at the practice easily. Longer appointments were available for patients if required, particularly for those with long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Staff worked well with the midwife and health visitor, who were based away from the practice, to provide prenatal and postnatal care. The practice achievement for baby and child immunisations matched the regional average.

Information relevant to young patients was displayed and health checks and advice on sexual health were provided. Chlamydia screening kits were available for young patients to take away with them.

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 practice provided appointments on the same day, although appointments could be booked up to a month in advance. The practice operated extended opening hours on Mondays and Wednesdays for emergencies or pre booked appointments. Appointments could be

Summary of findings

made either in person or by telephone. Patients generally reported that they could access appointments. Telephone consultations were available for patients, which benefitted those who worked during surgery hours.

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as requires improvement for the care of people whose circumstances may make them vulnerable. People wishing to register at the practice were always accepted. Home visits were provided to patients with mobility difficulties. Interpreters were used for patients who did not speak English. Not all of the staff had not received adequate training in safeguarding adults and children. GPs had training in the Mental Capacity Act (MCA) 2005 but healthcare assistants other staff did not have an adequate understanding or appropriate guidance available in relation to the MCA. This could affect the rights of patients who may lack capacity to make decisions about their care or treatment. Patients with a learning disability were in the process of being offered an annual health check at the practice, but this had not been fully instigated.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). Patients with mental health care needs were registered at the practice. Some patients with mental health needs had regular appointments with the practice nurse to help them manage their medicines. There was signposting and information available to patients, for example a counselling service.

The practice referred patients who needed mental health services to the local mental health team. The practice had recognised the need for patients who experience poor mental health to see a GP urgently and had changed it's appointment system to allow for same day appointments. Monitoring of medicines dispensed by the practice was undertaken in way that protected patients from the risk of inappropriate use of medicines.

Summary of findings

What people who use the service say

The practice had provided patients with information about the Care Quality Commission prior to theinspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We spoke with six patients during the inspection and collected four completed comment cards which had been placed in the reception area for patients to fill in before we visited. The majority of feedback was positive. Patients told us their care was very good, they had been listened to, they felt safe when being treated by staff, and they could access the practice easily. They told us that they found it easy getting an appointment for the same day especially if it was for a child.

We looked at patient feedback from the external national organisation used by the practice. The surveys reported that access to the practice was very good and patients could see a GP quickly. Patients felt that the GP was good at providing or arranging treatment. There was very positive feedback about the way staff spoke with and supported patients. All of the feedback was positive.

Areas for improvement

Action the service MUST take to improve

All staff must receive training in Mental Capacity Act 2005 and either training or updated training in safeguarding vulnerable adults and children.

Action the service SHOULD take to improve

Clinical Governance meetings should be held more frequently and a means of relaying any discussion and/or remedial actions to all staff should be introduced and formalised.

If reception staff are used as chaperones they must have received training to undertake this role.

A risk assessment regarding Legionella testing should be carried out.

Marlborough Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP specialist advisor.

Background to Marlborough Street Surgery

Marlborough Street Surgery at 1 Marlborough Street, Devonport, Plymouth PL1 4AE provides primary medical services to people living in the Devonport area in the city of Plymouth, Devon and there is also a branch surgery called Glendower in the area of Peverell in the city. Both practices provide services to a diverse population and age group.

At the time of our inspection there were approximately 5,000 patients registered at the Marlborough Street practice and approximately 1,000 patients at the Glendower surgery. Both practices share the same staff and patients can visit either practice. There were two full time male GP partners that held managerial and financial responsibility for running the business and worked full time. In addition there was two female salaried GPs who worked part time. The GPs were supported by two registered nurses, two healthcare assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

Marlborough Street practice is open from 8am until 6pm Monday to Friday and Glendower practice from 8:30am to 6pm each week day except Tuesday when the practice closes at 1pm. A late evening surgery is available at Marlborough Street two evenings a week for patients that find it difficult to visit the GP during the day. Patients could visit either practice. At weekends and when the surgery is closed, patients are directed to an Out of Hours service delivered by another provider.

Both practices are located in older buildings. The practice are in the process of starting a new build nearby.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting to inspect the practice, we reviewed a range of information we hold about the service and asked other organisations, such as the local clinical commissioning group, Local Healthwatch and NHS England to share what they knew about the practice. We carried out an announced visit on 15 October 2014. During our visit we spoke with three GPs, the practice manager, a registered nurse, administrative and reception staff. We also spoke with six patients who used the practice. We observed how patients were being cared for and reviewed comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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?

Detailed findings

- 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)

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice had processes in place to record near misses and incidents within the practice. Staff we spoke with were aware of the importance, and the processes of reporting any concerns that they had.

The practice used a range of information to identify risks and improve quality in relation to patient safety, this included reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses, they felt comfortable in doing this. Staff told us that the GPs would discuss any events reported to them.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last seven months and these were made available to us. The practice told us they hold clinical governance meetings to discuss areas of concerns within the practice. The meetings used to be held quarterly but are now bi annually due to difficult shift patterns and not being well attended. We looked at the minutes of the last two clinical governance meeting and the significant events log and could not see any evidence of learning recorded or feedback given to the staff.

We talked to one of the GPs about how the practice responded to safety alerts. We were told that the GPs assessed all safety alerts and made a judgement about whether it was appropriate to disseminate information to the rest of the staff at the practice. If it was deemed appropriate then the information would be communicated to the staff either by email or at the clinical meetings.

Reliable safety systems and processes including safeguarding

The GPs had undertaken safeguarding training, including to level 3 in relation to children, but were not aware of whether other staff had received safeguarding training. We asked the practice manager if training in this subject had taken place and we were told that a half day safeguarding training had been given during a clinical governance day and that new staff all received powerpoint slides on safeguarding as part of their induction. No records could be found to support this and the staff we spoke with were unable to recall attendance at this training.

We were told by a GP that the practice kept records of patients at risk of abuse on their individual files and that a "pop up alert" would be visible on their screen. They were not sure if these alerts were visible to receptionists when appointments were being booked, however a receptionist was able to explain to us how they were aware of the patient being at risk when they booked their appointment.

The practice offered a chaperone service. A chaperone is a member of staff who accompanies a patient during their consultation with a GP or nurse for medical examination or treatment. We were told that a nurse would undertake this role, but if they were not available then reception staff would attend. Receptionists had not received training for this. Patients also told us they could take someone, for example, a family member or friend, in with them.

Medicines Management

We spoke to one of the GPs about how they ensured prescribed medication remained effective and safe.

Other than the medicines used in the event of an emergency no medication was stored on the premises or in the GPs emergency bags. It was the responsibility of a healthcare assistant to check the stock of emergency medicines and expiry dates weekly. The nurse checked and recorded the temperatures of the refrigerators used to store vaccines twice a day . Staff recognised the importance of storing vaccines at the correct temperature ensuring patients received effective medicines. We saw that the recordings demonstrated that the medicines had been stored within safe temperature ranges. They told us that any abnormal temperature readings would be reported to the practice manager for action to be taken.

Patients had three options for ordering repeat prescriptions, they could post them to the surgery, hand repeat slip into the reception or order on-line. When a repeat prescription was required, the reception staff placed it in a folder for review. The GP would then review the prescription and the potential continued need for the medication.

Cleanliness & Infection Control

Requires improvement

Are services safe?

The practice had policies and procedures on infection control, staff were not clear as to who took the designated lead for infection control. We were told that a recent audit had been undertaken but this could not be found. However, flooring had been renewed in a treatment room as a result of this audit. Modesty curtains, where used, were either plastic or material. We were told that these were wiped down on a regular basis but there was no formal records to demonstrate when this had occurred or when they had last been cleaned.

Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. We spoke with the duty nurse and health care assistant who described the steps they took in between patient appointments, such as changing gloves, hand-washing, changing bed roll, and wiping the couch, to reduce risks of cross infection.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a written cleaning schedule for the cleaning staff. A system was in place for the practice manager to monitor cleaning routines and supervise cleaning staff.

Clinical waste and sharps were being disposed of in safe manner. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste.

Risk assessment regarding Legionella testing had not been carried out at the practice.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in January 2013.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

The practice had written guidance to support the recruitment and selection process of staff. Candidates were asked to provide documentation to verify their identity and qualifications. We also saw that a criminal records check had been carried out using the Disclosure and Barring Service (DBS). Clinical competence was assessed using questions at interview, and in practice throughout staffs induction process.

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

The registered nurses Nursing and Midwifery Council (NMC) status check was completed and checked annually to ensure they were listed on the professional register, thus able to practice legally. We saw evidence that the GPs were on the performers list.

Monitoring Safety & Responding to Risk

There were arrangements in place to deal with emergencies. Emergency medicines were available along with oxygen and an automated defibrillator (AED) with ventilation (breathing) equipment. However, this equipment was stored in a treatment room which could result in a patient receiving treatment being interrupted if the emergency equipment was required elsewhere. The staff had undergone basic life support training so that they could provide assistance with resuscitation until further help arrived.

In response to incidents and where patients demonstrated aggressive behaviour, staff had received training in how to deal with aggression. Panic alarms were installed in each room and policies written to help staff manage such situations safety. The policy document referred to reception staff never working alone, however, we observed a lone receptionist on the day of our visit.

Arrangements to deal with emergencies and major incidents

The practice had a contingency plan in place to deal with emergencies. The written plan included information on how to manage loss of computer systems, telephone

Requires improvement

Are services safe?

systems, failure of services such as gas and electricity and what to do if any staff were unable to work. It also included details of organisations to contact if any of this happened, meaning that disruptions to patients could be minimised.

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used The Quality and Outcome Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided.

Management, monitoring and improving outcomes for people

The practice showed us a clinical audit that had been undertaken in the last year. This was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example

a full audit cycle in relation to antibiotic prescribing had been conducted in 2013/2014. Audit results found that actions the practice had taken led to improvements in the management of antibiotic prescribing. This meant patients received safer treatment as a result of the audit.

We spoke with patients who regularly attended clinics to manage conditions such as chronic obstructive pulmonary disease [COPD] and heart problems. They spoke positively about the service they received and told us they understood the rationale and programme for management of their conditions. A patient who attended the COPD clinic told us the practice had a joined up approach. They explained their reviews included a blood test, weight management and then a medications review. They told us that this occurred every six months and there was a logical order followed so that all test results were available for the final medications review with the GP.

Effective staffing

Staff received regular appraisals within the practice but we were told that not all had been completed. Nursing staff had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council.

We were told that the practice operated an open door policy for the staff so any problems or issues could be discussed and addressed. The practice manager told us that they work in a supportive environment.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, hand over information from the out of hours providers, were received both electronically and by post. The partner GPs had the responsibility of reading this communication on the day and actioning any issues arising on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Regular multidisciplinary team meetings were held to discuss vulnerable patients, high risk patients and patients receiving end of life care. The multidisciplinary team included health visitors, district nurses, and the mental health team. Staff felt that this system worked well as a means of sharing information.

The practice worked effectively with other services. Examples given included work with the local mental health services, health visitors, specialist nurses, and community nursing staff .

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and

Good

Are services effective?

(for example, treatment is effective)

commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several electronic systems to communicate with other providers. For example, there was a shared IT system with the local out of hours provider to enable patient data to be shared in a secure and timely manner.

Consent to care and treatment

The GPs and nurses were aware of the Mental Capacity Act 2005 and their respective duties. Evidence showed they had been involved in best interest meetings where the patient did not have the capacity to make their own decisions with regards to understanding their choices about care and treatment.

The policy document giving guidance to the staff on consent was on the practice intranet, however staff members interviewed during the inspection made no reference to this. We were told by staff, who took blood, that patients gave implied consent, they had no examples of when consent had been sought before giving treatment. GP's told us that they gained verbal consent before giving any treatment and this was documented in the patients notes.

The practice is in the process of updating their list with patients with learning disabilities and arranging for these patients to receive an assessment by the healthcare assistants for their care plans. Training had been arranged for staff to assist with this process.

Health Promotion & Prevention

Information about health promotion and prevention was readily available to patients in the form of pamphlets, large print notices and printed sheets in the reception area, around the waiting room and corridors, and on the practice website. These included information on how to recognise signs of or prevent illness.

The practice offered clinics for patients with diabetes, respiratory problems and other conditions where health promotion discussions were part of the treatment plan. Screening clinics were held for conditions such as the early detection of diabetes and high blood pressure.

New patients registering at the practice completed a registration form that gathered comprehensive details of their health and lifestyle choices. All new patients were offered an appointment. The lead GP told us they used the registration form and initial appointment to identify patients who were at risk or required specific support with a long term condition.

The practice actively promoted and assisted patients in stopping smoking. Patients were able to book appointments with the practice nurses for support throughout the cessation process.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse.

Requires improvement

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients recieved or about the staff.

We saw that patient confidentiality was respected at the reception area with the waiting area downstairs being located away from the desk. This allowed for conversations between the staff and patients to remain confidential. The staff told us that another area could be used if requested by the patient. We observed throughout the day the reception staff speaking respectfully to the patients.

Access to the surgery was difficult for patients using wheelchairs, the practice had a mobile ramp that could be used. Patients were asked to inform the surgery if this adaption was required when booking their appointment. The GP consulting rooms were all located on the first floor with the only access being the stairs. For patients that were physically unable to climb the stairs a note was recorded on the patients record so the receptionists would be aware of booking the appointment in a treatment room located on the ground floor.

We observed that all consultations were conducted in a private room, however conversations could be overheard when standing on the landing. Not all of the GP consulting rooms respected the patients dignity, one had a blind for the window but did not have a curtain or means of screening the examination couch.

There was signage in the reception and each of the treatment rooms informing patients that they could request a chaperone (a person of their choice to accompany them) when being seen or treated by their GP. The patients we spoke with were aware of being able to use this service.

Care planning and involvement in decisions about care and treatment

Patients who we spoke to on the day of the inspection were happy with their involvement in the care and treatment they received. They told us that everything was explained thoroughly by the GPs and often backed up with written literature explaining medical conditions and treatments.

We asked several members of nursing staff about how they managed people's best interests when they lacked the capacity to make decisions. It was clear that some members of staff lacked knowledge about this subject area. We were able to confirm from training records and by speaking to staff that no formal training had taken place on the Mental Capacity Act (MCA) 2005These pieces of legislation are legal requirements that need to be followed to ensure decisions made about people who do not have capacity are made in their best interests. They are designed to ensure that people who are unable to give consent for certain aspects of their care and welfare receive the right type of support to make a decision in their best interest. One of the GPs that we spoke to clearly understood the ethos of the legislation but agreed they had received no formal training.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 87% of the 162 respondents to the patients survey said when it had been needed they were helped to access support services to help them manage their treatment and care. The patients we spoke to on the day of our inspection were also consistent with this survey information. We were given examples of where patients had been given additional support when caring for a relative.

Notices in the patient waiting room and on the patient website also signposted people to a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its patient population group and was responsive to their needs. Staff demonstrated an understanding of their patient population group and knew they had a larger than average number of patients with mental health issues and also those who were homeless. They had changed the way in which patients could make an appointment to see a GP. For example, they made more appointment time was given to accommodate patients that needed to be seen on the same day.

The practice had arrangements in place for patients whose first language was not English. The practice staff knew how to access language interpretation services to ensure, information was understood by patients to enable them to make an informed decision or to obtain verbal consent to treatment. Additional time was allowed for these appointments. However, there was not the facility to assist patients who were hard of hearing, so they may not receive the appropriate support to enable them to communicate with staff and understand their treatment.

There was a range of health-related information for patients available in the waiting room and on the practice website. For example, we found information explaining how patients could access out-of-hours care. Patients we spoke with understood where they could access advice and support when the practice was not open.

The practice was aware of and had links with a variety of other healthcare services to support patients. Staff had links with specialist nurses in learning disabilities, mental health and long term conditions. They were also able to refer patients to the local drug and alcohol support service and mental health service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of services. Staff told us that patients whose circumstances may make them vulnerable, for example, those who were homeless and living in a nearby hostel were able to register with the practice. Patients with no fixed abode had been registered as 'care of' the practice's address, but these patients were difficult for the practice to keep in contact with.

General access to the building was good, a ramp was available for patients in wheelchairs. The reception area and waiting rooms were small so due to the space constraints the practice asked patients to arrive just before their appointment and not to bring friends and family with them unless absolutely necessary. The GP consulting rooms were on the first floor, there was no lift in the building so alternative treatment rooms were available for patients and staff who were unable use stairs.

Access to the service

The practice operated an appointment system where the majority of appointments were booked on the day either by telephone or in person at the reception. Appointments for minor ailments could be made up to a month in advance. The practice kept times available at each surgery for patients who needed to see a GP urgently. Consultations could be held over the telephone after each surgery. An evening surgery was available for pre bookable appointments twice a week for patients who found it difficult to attend during usual working hours.

Patients we spoke with told us that they did not have to wait to long for an appointment and that they would always be seen if it was an emergency. They told us they might have to see a different GP and not the GP of their choice and they understood that.

Patients could telephone the practice after 2pm each day to obtain test results. These would be given either by the receptionist, or a telephone call booked with their GP if further information was needed.

We saw posters and literature on the wall in reception that sign posted patients to other care agencies if they needed them.

Listening and learning from concerns & complaints

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

The complaints policy was displayed in the reception area. The practice had responded to complaints in a timely way. There had been several formal complaints, these had been addressed in line with the practice's complaints procedures.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We spoke with patients about making a complaint. Patients told us they did not have a need to make a complaint but would talk to the practice manager and be confident that it would be resolved.

Are services well-led?

Requires improvement

(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. Staff knew and understood the vision and values and knew what their responsibilities were in relation to these.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and were positive about the open culture within the practice.

There was mutual respect shared between staff of all grades and skills. Staff appreciated the non hierarchical approach and team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally though meetings.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal . These meetings used to be held quarterly but are now bi annually due to difficult shift patterns and not being well attended. Any clinical or non clinical issues were discussed amongst staff as they arose. For example the GPs had an open door policy for colleagues to discuss cases and obtain a second opinion.

The clinical auditing system used by the GPs assisted in continuing improvement. All GPs were able to share examples of audits they had performed. These examples included audits on different medications being prescribed to patients. Audits were thorough and followed a complete audit cycle.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

We spoke with the GPs about their long term strategy for the practice. They told us they attended the locality group meetings within the local clinical commissioning group (CCG).The practice was looking towards moving to a more user friendly new building next year.

Leadership, openness and transparency

Staff within the practice had lead roles, for example there was a lead GP for safeguarding and a nurse for infection prevention control. Staff had an awareness of infection control and safety issues within the practice and their responsibilities to provide a good service, however not all findings were documented. The senior GP was unaware that he was the registered manager.

The staff all told us that they felt valued, well supported and knew that they could go to the practice manager with any concerns. A GP had also devised a spread sheet on the computer called “not a stupid question” that encouraged staff to ask questions and receive answers within the practice.

The practice manager was responsible for the human resource policies and procedures. These were all available on the practice intranet system. We were told that any changes or updates to these policies were communicated to the staff by each receiving a paper copy and having to sign the copy and a book in the reception to say that they had read it. However, not all staff spoken with were not aware of it’s existence.

Practice seeks and acts on feedback from users, public and staff

The practice did not have a patients participation group. The practice manager told us how they had tried to encourage interested patients but this had not been successful. The practice used an external organisation, to obtain feedback from patients on their service.

Overall the response to the latest survey in March 2014 was positive with patients being satisfied with the care and treat that they receive from their GP. The negative comments were in the main about the building which the practice recognised would be resolved when they moved to a new building next year.

Management lead through learning & improvement

Are services well-led?

Requires improvement

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

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice.

Staff told us that the practice supported them to maintain their clinical professional development through training. Staff told us that the practice was very supportive of training.

The practice had systems to discuss incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not ensure that staff were appropriately supported by receiving training in infection control, safeguarding adults and children or the Mental Capacity Act 2005 to enable them to undertake their responsibilities safely and to an appropriate standard. This was a breach of Regulation 23 of the Health and Social Care Act 2008(Regulated Activities) 2010 which corresponds to Regulation 18(2)(a)of the Health and Social Care Act 2008 (Regulated Activities) 2014.