Downham Family Medical Practice

Quality Report

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

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Summary of findings

Overall summary

Downham Family Medical Practice is situated in a Health and Leisure Centre in a residential area of Bromley and is a practice within Lewisham CCG.

The practice is registered by the Care Quality Commission to provide the regulated activities of Diagnostic and screening procedures, Family Planning, Surgical Procedures and Treatment of disease disorder or injury.

During our inspection we spoke with seven patients, and received twenty three comments cards which had been provided by the Care Quality Commission. Patients were positive about the service. They said they received effective treatment by caring staff.

We spoke with six staff from a clinical and non clinical background who were able to demonstrate knowledge and competence for their area of professional responsibility at the practice.

We found that some improvements could be made to improve the safe delivery of the service. The staff team could do more to learn from incidents and events. Improvements were also needed to plan and monitor training for staff and ensure the recruitment procedure was robust.

The practice asked patients for their views and a Patient Participation Group (PPG) represented patients. Efforts had clearly been made to build an effective PPG.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Many aspects of the service were safe but some improvements were required.

There were procedures in place to ensure accidents and serious incidents were identified. We found that information on learning from incidents did not always take place.

The practice had a process in place to ensure the staff recruited to work at the practice had undergone the required recruitment checks however in one personnel file we found checks were not robust.

There were procedures in place for protecting children and vulnerable adults and staff were aware of their role and responsibility within the safeguarding process. The practice was not able to evidence that clinical and non clinical staff had received training in safeguarding vulnerable adults.

Systems were in place for infection control and health and safety. Staff were not aware of the written guidance on the safe handling of patient samples.

Are services effective?

The practice worked with other health and social care providers to deliver care to patients with complex needs.

Training needs for staff were identified and planned to ensure they attended mandatory training although staff did not always have the opportunity to attend training for their professional development.

The practice had participated in clinical audits to evaluate the care and treatment of patients.

The practice was not utilising the public space available in the Leisure Centre or Public Library for health prevention and promotion

Are services caring?

Patients said they received the care and treatment they required from practice staff. Patients reported that staff were helpful respectful and caring. Information received from patients informed us that making an appointment could sometimes be difficult and there was a lack of privacy when they were at the reception area.

Summary of findings

Although some patients reported good access to appointments other patients experienced difficulty in making an appointment when they needed one. Some patients felt that it was difficult to get an appointment and waiting times at the practice were lengthy.

Are services responsive to people's needs?
The practice was responsive to patients needs.

Patients privacy was not always upheld due to the open plan layout of the reception and waiting area.

Are services well-led?
Many aspects of the service were well led but some improvements were required.

Leadership and governance arrangements were in place and staff were aware of their roles and responsibilities.

Systems were in place to monitor the quality of the service but areas for the improvement of the service were not clearly documented or incorporated into the practice business plan.

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
The practice had procedures in place to ensure older people were identified and their needs were assessed and met. The practice has a low number of older people.

People with long-term conditions
The practice cared for patients with long term conditions by ensuring they had good access to a GP. The practice nurse held clinics for specific conditions and monitored patients care and treatment.

Mothers, babies, children and young people
The practice had a range of services to meet the needs of mothers babies and children and your people. Services included a weekly clinic with the midwife, and childhood immunisations.

The working-age population and those recently retired
The practice had some arrangements in place to meet the needs of working age patients including extended opening hours one evening a week and the facility to order repeat prescriptions on line.

People in vulnerable circumstances who may have poor access to primary care
The practice supported people in vulnerable circumstances who may have poor access to primary care.

People experiencing poor mental health
The practice had procedures in place to deliver appropriate care and treatment to people experiencing poor mental health.

Summary of findings

What people who use the service say

The comment cards completed for the Care Quality Commission inspection informed us that the patients who had completed comment cards were satisfied with the practice and the care they received. Patients wrote that staff were helpful, respectful and caring.

The majority of patients spoke positively about staff and said most GPs offered an excellent service. Some patients commented that it could be difficult to get through to the practice on the telephone. One patient we spoke with had waited a week for an appointment but another patient reported being seen by a GP on the day of request. In addition most patients said they often had to wait beyond their appointment time, although they had seen some improvements in this regard. Patients said they used to sit and wait without any information but now they were told when they arrived if there was a delay and how many patients were in front of them.

Both patients and staff mentioned that the waiting area did not offer privacy whilst at the reception area. We were shown a room which was shared with another medical practice situated in the same location, which was used for private conversations. We were told this room was also used by mothers for breast feeding and for isolation of children who may have potentially contagious conditions such as chicken pox. Patients spoken to were aware of this room and their right to request a discussion in private. Most patients said they did not discuss anything personal at reception for this reason but some had overheard others having confidential conversations.

Patients we spoke with were not aware of the Patient Participation Group (PPG) or the specific clinics available at the practice. The PPG advised the practice on the patient perspective with the aim of patients and the practice working together to improve services. Information for patients on the practice, community health and social care resources was limited due to the lay out of the waiting room and a lack of designated space to display information.

Areas for improvement

Action the service SHOULD take to improve

Improvements should be made to the evaluation of learning from incidents and this information then used by the staff team to learn and further improve the care of patients.

Safeguarding documentation should be improved by ensuring the lead case worker was clearly identified.

A pre recruitment procedure and check list should be introduced to ensure that recruitment documentation for all prospective staff was robust.

Health and safety documentation relating to the safety of the premises and the practice cleaning arrangements should be requested from the facilities management team. This would enable the practice to monitor safety more effectively.

To improve patient safety in a medical emergency an oxygen cylinder should be available at the practice.

The practice should look at ways to improve the waiting and reception area for patients. This would improve privacy and confidentiality and ensure patient information was readily available and visible.

Joint working with other public services based in the same building could be introduced to promote health promotion and prevention.

A training plan should be devised which both monitored and identified the training needs of all staff. Staff training and development could be identified during the annual appraisal.

The business plan should identify improvements which could be made as a result of learning from significant events and the experience and opinions of patients.

Downham Family Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector a GP specialist advisor and a second CQC Inspector. The GP Advisor was granted the same authority to enter Downham Family Medical Practice as the CQC Inspector.

Background to Downham Family Medical Practice

Downham Family Medical Practice is based in the Clinical Commissioning Group (CCG) area of NHS Lewisham. The practice had 6713 patients registered with them at the time of this inspection.

Two full time GP partners and one salaried GP are employed at the practice. There are two male and one female GP. Other health care professionals and staff are a practice nurse, healthcare assistant, practice manager, six reception staff and an administrator.

The practice is situated in Downham Health and Leisure Centre. The centre provides community sports facilities, a library, a family planning clinic and two separately registered GP practices. The patient waiting area and reception area are shared between the two GP practices and situated adjacent to the entrance of the leisure centre. The whole of this ground floor area is open plan with a shared space for people using sports facilities and patients attending an appointment with their GP.

The practice was open from 8.00 to 18.30 Monday to Friday. The practice had extended opening hours on Thursday evening when the practice closed at 20.00.

In this CCG area 46.5% of the population belong to non-white minorities which is higher than the England average. There is a higher percentage of people registered with a GP who are eighteen years and younger than the national average. Conversely there are lower numbers of patients registered with the practice aged sixty five and over.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Detailed findings

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 11 July 2014.

During our visit we spoke with a range of staff including GPs, the practice manager, the nurse practitioner, a health care assistant and reception staff, and we spoke with patients who used the service.

We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We spoke with seven patients and received twenty three comments cards.

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

Are services safe?

Our findings

Many aspects of the service were safe but some improvements were required.

There were procedures in place to ensure accidents and serious incidents were identified. We found that information on learning from incidents did not always take place.

The practice had a process in place to ensure the staff recruited to work at the practice had undergone the required recruitment checks however in one personnel file we found checks were not robust.

There were procedures in place for protecting children and vulnerable adults and staff were aware of their role and responsibility within the safeguarding process. The practice was not able to evidence that clinical and non clinical staff had received training in safeguarding vulnerable adults.

Systems were in place for infection control and health and safety although there was no written guidance for staff on the safe handling of patient samples.

Safe patient care

We saw that the practice had arrangements in place for reporting and recording significant events, which included incidents which may have a negative impact on patients; for example medication errors.

We were informed by the practice manager that the facilities team had access to all parts of the health and leisure centre including the Downham Family Medical Practice. As a result of this security arrangements had recently been improved. All doors within the practice had now been fitted with swipe cards and door codes which were only available to staff who worked at the practice.

Learning from incidents

We were informed that significant events were discussed in clinical meetings. Minutes of clinical meetings were inspected, and whilst these evidenced discussion of patient care and services, discussion of significant events was not minuted. The practice was not able to evidence how the staff team learnt from significant events.

Safeguarding

The practice had measures in place for child protection and safeguarding vulnerable adults. A child protection policy and a safeguarding adults policy were available for staff guidance. Staff were aware of their responsibility within the safeguarding process. Lead GPs were designated for child protection and safeguarding vulnerable adults, respectively. GPs and nurses had attended Level 3 training in child protection. Reception staff had attended Level 1 training in child protection. We were informed that the practice staff had received training in safeguarding vulnerable adults, however this was not recorded on the training record/schedule we were provided with.

The staff at the practice were aware of the families registered with them where child protection concerns had been identified and were being addressed by health and social care agencies. We saw that practice meetings were held weekly between the GPs, practice nurses, health visitors and school nursing service. This was evidenced by the minutes of practice meetings. The child protection and safeguarding adults records we saw at the practice did not identify the lead case worker within health or social services. We discussed this with the principal GP and practice manager and were informed that the health visitor was the link between the practice and social services.

Monitoring safety and responding to risk

A risk assessment of potential hazards had been completed. This assessment included the impact of events which may pose a disruption to patients and their care. The level of risk had been calculated in each identified area. As a result of this an Emergency and Business Continuity Plan was available for staff to guide them on the action to be taken in the event of an incident. We saw from records that fire alarm testing and an evacuation had taken place on 13 December 2013.

Training records indicated that GP's had received training in resuscitation. We saw evidence that two GPs had received training in the use and interpretation of Electrocardiograms (ECGs.), the recording of electrical activity in the heart. The staff training schedule identified that non clinical staff were booked to attend resuscitation training on 30 August 2014. The practice had a defibrillator on the premises but the practice did not have an oxygen cylinder.

Medicines management

Fridges where medicines were stored were being kept at the correct temperature. A practice nurse was responsible for ensuring vaccines were kept at the correct temperature prior to administration.

Are services safe?

We looked at the doctors 'visiting bag' which was appropriately stocked for home visits and medicines were checked by the practice nurse to ensure they were within their use by date.

Cleanliness and infection control

The practice was visibly clean. Patients we spoke with said they found the consulting rooms to be clean but commented that the shared reception/waiting areas looked worn. We looked at the cleaning schedule for the practice. This was forwarded to us, on request, after the inspection visit. A contract cleaning company were responsible for cleaning at the practice. We saw there was a daily, weekly and monthly cleaning schedule for all of the areas of the practice.

The practice nurse had been designated as the lead for infection control. Records evidenced that infection control audits were taking place. We looked at one infection control audit conducted on 8th July 2014. The audit covered general management of the premises, personal protective equipment for staff, decontamination of instruments, waste management and storage of vaccines. Where the practice had identified areas for improvement an action plan had been developed with dates for completion. There were no outstanding actions at the time of the inspection.

We spoke with staff who confirmed there was a process in place for receiving and handling samples and specimens. However, the staff we spoke with were not aware of the written guidance on safely managing samples and specimens.

Staffing and recruitment

We looked at the recruitment records of four members of clinical and non clinical. We saw Disclosure and Baring Service (DBS) checks were in place. References had been sought as part of the recruitment process but these were not always robust. For example, one candidate did not have a reference from a previous employer and another candidate's reference was not addressed to the referee. Therefore it was not evident that this reference had been requested by the practice as part of their recruitment process. One of the recruitment records viewed did not contain photographic proof of identity.

We saw General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration numbers were recorded for clinical staff. GMC Revalidation dates had been set and recorded for GPs.

There was a new staff induction check list, and induction training for staff that had recently started working at the practice. Staff who had work

The premises at Downham Family Medical Practice were managed by the facilities management team of the Downham Health and Leisure Centre. All aspects of premises health and safety management, for example, fire equipment testing, was managed by the facilities team. Health and safety documents were held with the facilities team and were not available to view on the day of the inspection.

Dealing with Emergencies

The premises at Downham Family Medical Practice were managed by the facilities management team of the Downham Health and Leisure Centre. All aspects of premises health and safety management, for example, fire equipment testing, was managed by the facilities team. Health and safety documents were held with the facilities team and were not available to view on the day of the inspection.

The practice had an Emergency and Business Continuity Plan. A member of staff was the designated person for contingency planning and was responsible for coordinating the response in the event of an emergency. The plan set out action to be taken in the event of accidents and incidents in relation to the premises, incapacity of staff and loss of facilities such as electricity and loss of IT functions affecting electronic patient information.

Training records indicated that GP's had received training in resuscitation. We saw evidence that two GPs had received training in the use and interpretation of Electrocardiograms (ECGs.), the recording of electrical activity in the heart. The staff training schedule identified that non clinical staff were booked to attend resuscitation training on 30 August 2014. The practice had a defibrillator on the premises but the practice did not have an oxygen cylinder.

Equipment

Equipment used at the surgery was included in the infection control audit and the safety of equipment was

assessed as part of this audit. The practice had a policy on how to use and clean medical equipment as recommended by General Guidance and National Specifications.

We requested and were forwarded evidence of equipment safety testing and calibration. Equipment such as the baby scales, thermometers, blood pressure monitors and the defibrillator had been serviced. Portable electrical appliance testing (PAT) had taken place in April 2014.

Are services effective?

(for example, treatment is effective)

Our findings

The practice worked with other health and social care providers to deliver care to patients with complex needs.

Training needs for staff were identified and planned to ensure they attended mandatory training although staff did not always have the opportunity to attend training for their professional development.

The practice had participated in clinical audits to evaluate the care and treatment of patients.

The practice was not utilising the public space available in the Leisure Centre or Public Library for health prevention and promotion.

Promoting best practice

We saw evidence of how the National Institute of Care and Excellence (NICE) Guidelines were accessed during consultations with patients. However, there was no formal system for staff to meet and discuss best practice guidelines.

We saw records which evidenced that there had been decrease in the prescribing of antibiotics and non-steroidal anti-inflammatory drugs for patients. This was as a result of an audit carried out by the senior partner on the prescribing of these medicines within the last 12 months.

There had been an increase in the diagnosis of dementia by GPs in the last 12 months due to the increased use of the General Practice Assessment of Cognition (GPCOG) assessment tool. Given the low number of elderly patients registered at the practice the numbers of patients assessed remained low but the percentage assessed increased.

The practice had conducted clinical audits on the cycle of treatment given to patients with diabetes and an audit on minor surgery which had been undertaken at the practice.

The GP undertaking minor surgery maintained a detailed log of all procedures undertaken and had audited his performance as part of his GP appraisal.

Management, monitoring and improving outcomes for people

The practice used the Quality and Outcomes Framework to monitor, benchmark and improve the service. QOF is a voluntary annual reward and incentive programme detailing GP practice achievements. For example, management of chronic disease, patients experience of their care, additional services and how well the practice is organised. We saw evidence of GPs using online antibiotic prescribing guidance, and data on improved performance in prescribing non-steroidal anti-inflammatory drugs (NSAID.) An audit had been carried out on Quality Outcomes Framework (QOF) exception reporting.

Staffing

The practice nurse informed us that she attended practice nurse forums with other practice nurses in the Lewisham Clinical Commission Group area. Practice nurse forums took place once every three months. Agenda items for the forums included common health conditions such as asthma and cardiopulmonary disease and infection control practices.

Reception staff had monthly meetings with the practice manager to discuss issues such as the management of patient information and working with patients in the waiting room and reception area.

Policies and guidelines were available for staff on bullying and harassment and whistle blowing. The whistle blowing policy informed staff how to report bad practice to external organisations if they witness this happening whilst at work.

Staff training certificates were kept but neither a schedule of current training or a training plan were available. The practice manager asked staff for an update on the training they had attended, and a staff training record was sent to us after the inspection visit. All of the clinical staff had attended training in Level 3 child protection, with non clinical staff were due to attend this in August 2014. Two GPs including the principal GP had attended resuscitation training in 2013 and all of the staff team had been booked to attend resuscitation training on 30 August 2014. The majority of the staff team had attended training on information governance.

The practice nurse informed us that she had received extensive training relevant to her role, although nurse training had not been recorded on the training plan sent to us by the practice. GPs had been given dates for their revalidation with the General Medical Council.

Working with other services

We saw evidence of multi-disciplinary team meetings in the form of meeting minutes. Clinical staff met with mental health professionals on a monthly basis to discuss patient care. A weekly meeting took place with practice staff and

Are services effective?

(for example, treatment is effective)

health visitors/school nurses to discuss the welfare of children who were being monitored under child protection procedures. Weekly meetings were arranged between clinical staff, district nurses and the community matron to monitor and review people being cared for in the community.

The practice worked with the Community Mental Health Team (CMHT). If patients did not attend appointments at the practice the CMHT were contacted with this information. We were informed practice staff were invited and attended patient review meetings at the CMHT.

Patients at the practice were able to book an appointment with the Improving Access to Psychological Therapies Team (IAPT). The IAPT team and bereavement counsellors were available to support patients at the practice four days a week. As a result of multi – disciplinary meetings patients were also referred to the IAPT team by GPs.

The practice was located in a Leisure Centre where there was also a Public Library, another GP practice and a sexual health clinic. When we spoke with staff it was apparent that the practice did not liaise with the other services in the building to explore and promote health promotion and prevention.

Health, promotion and prevention

The practice nurse was responsible for undertaking patient smear tests and promoting sexual health. She informed us she had attended a course on 'Sexual Health in Practices' with the support of the principal GP.

The practice nurse held a sexual health clinic with the primary purpose of offering health and educational support on a variety of sexual health issues. An example of this was the correct use of condoms for contraception and sexually transmitted infection prevention. The nurse informed us she had received training relevant to her role although this was not recorded on the training record.

Evening appointments were available for smear testing to enable working women to attend their appointment after work. As a consequence of this the practice had met the CCG target for smear testing up to 80% of female patients.

We saw minutes of meetings which indicated that reception staff met with the practice manager to discuss the information they would request from new patients regarding lifestyle choices. The purpose of this was to ensure patient registration forms included information relating to smoking, alcohol consumption and psychological health. We were informed by staff that clinicians could recommend books on certain aspects of health promotion, and patients could access these from the library which was in the same building as the practice.

Are services caring?

Our findings

Patients said they received the care and treatment they required from practice staff. Patients reported that staff were helpful respectful and caring. Information received from patients informed us that making an appointment could sometimes be difficult and there was a lack of privacy when they were at the reception area.

Although some patients reported good access to appointments other patients experienced difficulty in making an appointment when they needed one. Some patients felt that it was difficult to get an appointment and waiting times at the practice were lengthy.

Respect, dignity, compassion and empathy

We received twenty four comments cards completed by patients for the Care Quality Commission inspection of Downham Family Medical Practice. The information we received informed us that patients were satisfied with the practice and the care they received. Patients wrote that staff were helpful, respectful and caring.

We looked at the results of the National Patient Survey and the views of patients who had reported their experience on the NHS Choices website. Patient information from the National Patient Survey informed us that some patients had a poor experience of trying to book an appointment at the surgery. Also, patients said they could be overheard when talking with receptionists in the reception/waiting area. Once in the waiting area patients reported waiting over fifteen minutes for their consultation. Patients experience of receiving treatment by the practice nurse was reported as being good.

Five patients had left information on the NHS choices website reporting difficulty in getting an appointment. Six patients said that GPs were efficient and listened, staff were professional, receptionists helpful and they were satisfied with the opening hours.

We looked at the results of the patient survey conducted by Lewisham CCG. Patients at Downham Family Medical Practice were asked to rate their experience. Patients who responded to the survey rated their experience of care and concern and being listened to by staff as better than expected. Patients experience of making an appointment and then being overheard at reception was rated negatively. The majority of patients spoke positively about staff and said most GPs offered an excellent service.

When we spoke with both patients and staff at the surgery they mentioned that the shared waiting and reception area did not offer privacy for patients. There was a room which could be used for a private conversation with reception staff. This room was shared with the other medical practice and was also used for breast feeding and children who may have conditions such as chicken pox.

The practice had a female GP and a chaperone policy was in place for patients who required this service.

Involvement in decisions and consent

We saw evidence that the practice sought appropriate verbal and written consent for treatment received at the practice and this was in line with National guidance.

The practice had counselling rooms and patients were referred to this counselling service. Both general counselling and counselling and support for bereavement were available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patients needs.

Patients privacy was not always upheld due to the open plan layout of the reception and waiting area.

Responding to and meeting people's needs

We were informed that the practice had allocated morning appointments to older patients; this was a priority during the winter months. The reason for this was to ensure older patients did not have to attend the practice in the late afternoon or evening when it was dark.

A female GP was available for female patients if this was the patients preference. A chaperone policy was in place and health care assistants and occasionally reception staff were designated as a chaperone if this was requested by the patient. Evidence of staff training in chaperone duties was not available.

An interpretation service was in place to assist patients and GPs with communication.

Patients we spoke with were not aware of the specific clinics available at the practice. We observed that information for patients about the practice, community health and social care resources was limited due to the lay out of the waiting room and a lack of a designated space to the display information.

Patients with long term conditions were reviewed and a system was in place to recall patients for further monitoring and review. We were informed that an 'alert' was placed on individual electronic patient record where risks to a patient's health and wellbeing had been identified. For example, appointment requests for people who had a mental health condition or children at risk would be prioritised.

The Patient Participation Group (PPG) at Downham Family Medical Practice had been set up three years earlier. Members from this group told us that they met four times a year. The PPG was currently advertising for a chair person, the practice manager was the chair person at the time of the inspection. Information on the PPG was displayed in the waiting area; however, we observed that this information was not displayed in a prominent position and patients spoken to were not aware of the group's existence. We were informed by the practice that they planned to attach information on the PPG to new patient registration forms.

We spoke with two patient representatives who attended the PPG. We were informed the purpose of the PPG was to improve the service for patients, listen to issues of dissatisfaction and suggestions for improvement. We were informed that as a result of feedback from patients the chairs in the waiting room had been replaced. The representatives said the shared open plan reception/ waiting was an area of concern for some patients as conversations could be overheard, however they confirmed that a private room was available for conversations of a confidential nature.

An on-line appointments booking system had been tested at the practice over the last nine months. There had been some technical problems with the IT system providing this service. We were informed that the PPG had not received any feedback about this pilot even though they had raised concerns about its accessibility. We were also told that members of the PPG felt it was extremely important for clinical staff to attend the PPG meetings to hear patient views. Meeting minutes evidenced that only one clinical staff member had ever attended one PPG meeting.

From the practice web site it appeared that the same record for the annual PPG meeting had been used in both 2013 and 2014. This was pointed out to the practice and it was agreed that this error would be corrected.

Access to the service

Some patients commented that it could be difficult to get through to the practice on the telephone; there could also be a long wait for an appointment and then a long wait once at the practice for the consultation. One patient we spoke with had waited a week for an appointment but another patient reported being seen by a GP on the day of request.

There were a number of options for patients who wished to book appointments at the practice. Appointments could be made two weeks in advance. We were informed that children under two, families at risk, people with mental health problems and long term health conditions were given an appointment or telephone consultation on the day of their request. An alert was attached to the patient electronic recording system to identify this category of

Are services responsive to people's needs?

(for example, to feedback?)

patient. Reception staff we spoke with were aware of their responsibility to respond to patient requests and concerns, and to ensure the GP's or practice nurse were forwarded this information in order for a decision to be made about their care and treatment.

An 'open surgery' was available every morning between 9.00 and 11.30. Patients were booked on the day then had the opportunity to wait to be seen by a GP.

Patients who called with a medical emergency were transferred to a GP for a telephone consultation. The GP would then assess their medical condition and determine if there was a need for immediate medical intervention. We were informed by staff that the GP 'on duty' was designated to speak with patients on the phone if the patient requested an emergency appointment. The locum GP would then carry out an assessment with the patient on their medical needs.

Patients who required a consultation and treatment 'out of hours' were referred to an alternative provider. Information on this was included in a patient information leaflet.

Concerns and complaints

The practice had a complaints procedure but this was not displayed. Patients were able to collect a copy of the complaints procedure and a complaints form from reception. We were informed by the practice manager that the first stage of a complaint was to discuss the patients grievance informally with them. We saw that one complaint had been recorded and responded to appropriately within accepted timescales set by the practice.

Are services well-led?

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

Our findings

Many aspects of the service were well led but some improvements were required.

The provider had leadership and governance arrangements in place and staff were aware of their roles and responsibilities.

The views of patients were sought through the PPG and patient surveys conducted by the practice. Patient experience was not reviewed alongside other performance information or included in the business plan.

Systems were in place to monitor the quality of the service but areas for the improvement of the service were not clearly documented or incorporated into the practice business plan.

Leadership and culture

The practice strategy document gave a clear vision of aspirations for moving forward but this vision was not clearly identified in the practice leaflet or reflected in the new patient questionnaire.

We saw evidence of clinical team meetings where patient care and treatment was discussed. Some of the topics discussed in clinical team meetings were safeguarding children, end of life care and caring for patients with complex needs.

The practice manager held meetings with reception and administrative staff where communication and liaison with GPs was reviewed as well as the appointment system and administrative work.

Governance arrangements

We spoke with staff who were aware of governance arrangements at the practice. The principal GP was responsible for overall decision making at the practice and staff were aware of their accountability to the principal GP.

Staff at the practice had a designated lead role. For example GP's were the lead for safeguarding adults, child protection and medicine prescribing. The practice manager led on health and safety and the supervision of reception staff, the practice nurse led on vaccine storage, infection control, women's health and sexual health.

Arrangements were not in place to ensure that the quality of care and staff performance were regularly reviewed.

Systems to monitor and improve quality and improvement

We saw that a clinical audit cycle was in place for treating patients with diabetes, patient episodes of minor surgery and an audit of exception reporting for the QOF Quality Outcomes Framework. We did not see evidence of the actions that had been taken as a result of these audits and how the information from the QOF audit could lead to an improvement services for patients. This was therefore deemed to be an incomplete audit .

We saw a business plan dated July 2014. The plan covered a brief overview of the practice, the core values of the practice and information on the premises and staffing. A 'business for the next two years' section set out how the practice worked with all patient groups including children, families and older people. People with long term conditions and mental health needs were also identified. However, the business plan did not include a strategy for improvement, there were no specific actions to be implemented, no designated lead to implement improvement and no allotted time scales.

Patient experience and involvement

Information on the comment cards completed for the Care Quality Commission inspection informed us that patients were satisfied with the practice and the care they received. Patients wrote that that staff were helpful, respectful and caring.

The PPG met four times a year and patients were able to express their views and make suggestions on how to improve the service. Patients who attended the practice had the opportunity to complete a feedback questionnaire and return it to the practice. We did not however see evidence of patient views and involvement being reflected in the business plan.

Patient surveys were carried out once a year by the practice. Surveys were given out to patients by reception staff. Patients were asked for their views and their experience with regard to appointments, access to a GP, the electronic repeat prescription process, and their awareness of different services provided by the practice. The surveys were only available at the reception desk and consequently only patients who attended the practice would be aware of the survey. At the time of the inspection the outcome of the most recent survey was not available.

Are services well-led?

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

Learning and improvement

There was no formal process for staff to discuss and learn from mistakes, incidents and complaints. A variety of staff meetings were held and these meetings focused on individual patient care and meeting the treatment needs of patients.

Identification and management of risk

The practice had a contingency plan for risk assessed circumstances which might affect the running of the practice.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a relatively low percentage of patients registered with the practice, compared to the clinical commissioning group average who were over the age of the 75. The practice nurse was involved in managing the care of older people who required long term care due to high medical support needs.

The practice had identified patients over the age of 75 and had started to develop care plans for older people who required enhanced services - a programme of care tailored to meet the patient's needs and overseen by a designated and named GP.

There was a triage system for people over the age of 75 to ensure they were identified for appointments.

The practice kept a register of patients over the age of 65 and offered them an annual health check.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The care of people with long term conditions was nurse led. The practice worked closely with other services that care for people with long term conditions, such as the district nursing service and the community matron. People with long term conditions were able to pre book an appointment with a GP.

Specific clinics were held at the practice for asthma, lung diseases and diabetes. The practice nurse had a dedicated time within her schedule to work with people who had a long term condition.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The Community midwife held a clinic at the practice once a week so pregnant women had a choice of receiving care and follow up appointments at the practice instead of going to a clinic at the hospital.

The practice monitored the uptake of the MMR vaccine. The uptake for this vaccine was at the average level for other practices within this CCG area. If there was a difficulty contacting parents with regards to their child receiving the vaccine the practice would work with the school nursing service to ensure that parents were given the information and opportunity to have their child vaccinated.

The practice worked with health visiting services and the school nursing team to ensure that children registered at the practice received services such as nutrition and healthy development, prevention and safeguarding from harm.

The practice worked with the school nurse and health visitor to ensure that the care and welfare of children and families who were on the child protection register were monitored.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

Patients who were not able to attend the surgery during working hours had the option of making an appointment to see a GP on a Thursday evening for extended hours. Appointments were available on this day until 20.00. The practice nurse was also available to carry out smear tests one evening a week until 19.30.

Telephone consultations were available for patients who could not attend the surgery and an on line medication/ prescription request service was available for prescribed medicines to be collected from a named pharmacy.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice worked with primary health care services and social care services to ensure that people in vulnerable circumstances had their care monitored and their needs met.

The main group identified was of new immigrants who did not speak English and had little or no knowledge of how to access NHS health services. The numbers in this group were small but have been considered by the practice.

Patients who were vulnerable were identified on the patient electronic recording system and were given prompt access to appointments. Reception staff were made aware of vulnerable patients and instructed to ensure vulnerable patients were given time to come in and see a GP even if the appointments system was fully booked.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice held a register for patients who had mental health problems and offered patients in this category annual health checks.

The practice worked with the local Community Mental Health Team (CMHT). The CMHT took the lead in managing the care of patients with complex mental health needs.

Patients experiencing a mental health problem were identified on the patient electronic record system to ensure they had access to appointments when they needed them.

IAPT services and bereavement counselling were available at the surgery to support people with psychological and emotional disorders.