City 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.

Summary of findings

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Summary of findings

Overall summary

City Medical Practice provides a range of primary care medical services to approximately 9,120 people from a purpose built surgery. The practice has a branch surgery at Newlands Heath Health Centre, 34 Newland, Lincoln LN1 1XP. Patients are able to attend either surgery.

During our visit we spoke with 25 patients who used the service and met with seven members of the Patient Participation Group. We spoke with eight members of staff. We also looked at procedures and systems used and considered whether the practice was safe, effective, caring, and responsive to patients' needs and well led.

All of the patients we spoke with were very complimentary about the care and treatment they had received and said that the practice provided a satisfactory service for them. Patients reported they had been treated with respect by attentive staff. We saw that the results of patient surveys carried out by the practice, showed that patients were pleased with the service they had received and that the provider had responded to their views and complaints.

City Medical Practice was safe. There were appropriate safeguarding procedures in place. Medicines were managed safely, the practice was clean and hygienic and there were arrangements in place to respond to emergencies.

The practice was effective and had procedures in place that ensured care and treatment was delivered in line with appropriate standards. Staff were trained to work effectively and there were links with other providers in the area.

The practice was caring. Patients were treated attentively and with dignity and respect. Patients spoke very positively of their experiences and of the care and attention offered by staff. The GPs provided personal intervention in patients' end of life care.

The practice was responsive to patients' needs and met the needs of patient groups within its local population, such as patients from particular ethnic backgrounds. The practice had an accessible appointments system and was also accessible to patients with limited mobility and to those whose first language was not English.

The practice was well led and there was a philosophy of attentive care that was shared by all staff. There was an active patient representation group in place. There were effective governance procedures in place and a system of using information from patients and from records to monitor the effectiveness of the 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?

City Medical Practice was safe. Patients received care and treatment from staff who were suitably skilled and qualified. There were arrangements in place for reporting safety incidents and a culture of learning from these incidents. There were safeguarding procedures in place to protect children and vulnerable adults that followed appropriate guidance.

Staff followed infection prevention and control guidance and ensured that regular cleaning of the practice's premises was carried out. The practice had identified and managed the risks to people's safety. There were plans to ensure that the practice could continue to operate in the event of a major incident.

Medicines, including emergency medications and vaccines were handled, stored and monitored to ensure they were safe to use. Staff had basic life support skills to ensure they could care for patients safely in an emergency.

Are services effective?

The practice was effective. There were procedures in place for providing treatment and care that was in line with national standards and guidelines. Patients were well informed about their condition and had been included and involved in their care. Consent was obtained and care and treatment was discussed with patients in order for them to make informed decisions about their options and lifestyle choices and self-management of their condition.

The practice had health promotion and prevention systems in place, and was effective at monitoring, managing and improving outcomes for patients. There was an effective system in place to manage the health reviews of patients with long term conditions and patients who were receiving care at the end of their lives. There were effective links and collaborative working with other health and social care providers.

Staff had training that they needed to carry out their roles effectively and this had ensured that patients received appropriate treatment from suitably skilled staff. All staff were supported and were appraised annually.

Summary of findings

Are services caring?

The practice was caring. Patients were treated with respect and compassion by staff. We saw examples during our inspection of patients being treated with respect, dignity, compassion and empathy by staff.

Patients spoke positively of their experiences and of the care and attention offered by the staff.

Patients receiving mental health care and treatment and patients whose first language was not English were shown consideration. Patients receiving end of life care were provided with personal care by the GPs at the practice.

Are services responsive to people's needs?

The practice was responsive to patients' needs. There was an appointment system that ensured that patients were offered an immediate appointment for urgent cases. The practice had increased its patient population and had met the needs of specific patient groups within its local population, such as patients from particular ethnic backgrounds.

The practice had accessible emergency appointments and prescription arrangements. The practice was accessible to patients with limited mobility, or whose first language was not English. However, several patients reported they had to wait too long for routine, or non urgent appointments and had experienced delays when accessing the practice by telephone.

There was a clear complaints policy and patients' complaints had been consistently responded to in a thorough and attentive manner.

Are services well-led?

The practice was well led. There were effective governance structures which included regular communication both within and external to the practice.

The practice made use of information acquired directly from patients and information held electronically to manage and improve the provision of its services.

It was unclear what actions the provider had taken when audits had been carried out.

The practice was supportive of staff development and of patients' views. Staff and members of the Patient Participation Group (PPG) were supported and listened to by the practice.

Summary of findings

What people who use the service say

The latest annual patient survey action report completed by the practice in March 2014 showed that almost all patients were satisfied with their care and treatment. The 25 patients we spoke with during the inspection said they were very satisfied with the care and treatment they had received. They also made similar positive comments about the respect and the kindness shown by clinical staff and reception staff.

We found that 46% of the 183 respondents to the practice's annual survey reported they were not satisfied with the delayed response they encountered whenever they telephoned the surgery. The General Practice Outcomes Standards (GPOS), an NHS England measurement of patient satisfaction, identified that patients of this practice had a low satisfaction rate when asked about access to the service.

We provided comment cards for patients to complete when they attended the practice, although we received only one comment card from one patient. They commented that the practice was good.

Areas for improvement

City Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector and a GP specialist advisor and the team included a practice manager specialist advisor and two additional CQC inspectors plus an expert by experience. An expert by experience is a person who has experience as a carer, or as a patient of health services.

Background to City Medical Practice

City Medical Practice, in the West Lincolnshire Clinical Commissioning Group (CCG) area, provides a range of primary medical services to approximately 9,100 patients. The practice has a main surgery and a nearby branch surgery that are both located in the City of Lincoln. The main surgery is a purpose built GP surgery.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward and at the same time as a group of other practices in this CCG area. This practice had not been inspected before and that was why we included them in this group of inspections.

How we carried out this inspection

We conduct our inspections of primary medical services, such as City Medical Practice, by examining a range of information and by visiting the practice to talk with patients and staff. 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 01 May 2014. During our visit we spoke with 25 patients and with carers and parents whilst they were waiting to attend appointments. We spoke with seven representatives of the Patient Participation Group. We also spoke with a range of staff, including two nurses, two GPs, four reception and administration staff, and the practice manager. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents.

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?

Are services safe?

Summary of findings

City Medical Practice was safe. Patients received care and treatment from staff who were suitably skilled and qualified. There were arrangements in place for reporting safety incidents and a culture of learning from these incidents. There were safeguarding procedures in place to protect children and vulnerable adults that followed appropriate guidance.

Staff followed infection prevention and control guidance and ensured that regular cleaning of the practice's premises was carried out. The practice had identified and managed the risks to people's safety. There were plans to ensure that the practice could continue to operate in the event of a major incident.

Medicines, including emergency medications and vaccines were handled, stored and monitored to ensure they were safe to use. Staff had basic life support skills to ensure they could care for patients safely in an emergency.

Our findings

Safe patient care

We found that patients' records were stored as protected records, accessible only by authorised staff employed at the practice. We saw that patients' history and their treatment notes had been recorded in detail.

The practice discussed patients at risk during the regular practice meetings and clinical meetings. There was further evidence of this in the notes kept of the regular multi-disciplinary palliative care meetings. We also saw how a chronic obstructive pulmonary disease register was used by the practice to support the clinical reviews for this group of patients. We saw evidence that for patients' with a mental health diagnosis, a review of their medication and their physical health had been carried out.

The practice ensured patient safety because they were seen by clinical staff who had continued with their professional development and remained registered with their respective professional bodies.

Automatic alerts about patients' assessed health risks and any known safeguarding risks were built into the computer held patient information. This had enabled GPs and nurses to immediately identify patients with known risks. We saw that information about children at risk was held on their records and this had ensured that clinical staff at the practice were alerted whenever a child was presented for treatment.

Learning from incidents

We saw that patient safety incidents had been reported in line with NHS National Patient Safety Agency (NPSA) guidelines. We saw evidence that learning consistent with the National Framework for Reporting and Learning from Serious Incidents through significant event analysis (SEA) had taken place. We saw that when national or local safety alerts came into the surgery, relevant staff were made aware them.

Learning sets, which were opportunities for staff to discuss the importance of these events and learn from them, were a regular feature of the practice meetings and the clinical meetings were evident in the palliative care meeting records. We found that lessons learned from incidents had been implemented. For example, in the case of a medicine error check, this had been acted upon to reduce the chance of recurrence. This open and transparent approach

Are services safe?

to sharing learning from incidents helped to inform the practice of professionals working across different organizations and supported the improvement of patient care.

Safeguarding

The safeguarding policies for children and for vulnerable adults included a named lead GP responsible for safeguarding matters. We spoke with one clinical member of staff who was able to demonstrate they would respond appropriately should there be a concern or an allegation of abuse. Non clinical staff we spoke with demonstrated they would report any safeguarding concerns to a GP or a nurse.

The practice had a system to identify patients at risk and we saw that there were alerts on records that informed GPs and nurses where there were any safeguarding concerns.

We found that the practice had worked with their Clinical Commissioning Group (CCG) for support and training with safeguarding. We were told that sometimes a safeguarding matter would be discussed at a practice meeting, although the practice did not have a systematic approach to review safeguarding concerns that were known to them. The senior GP informed us that they would expect to be kept up to date by the Local Authority Children and Family team with any changes to the safeguarding circumstances of any child registered with the practice who was the subject of a child protection plan. We saw that the practice had shared information with the local authority in accordance with local safeguarding procedures with information about children who were at risk.

Monitoring safety and responding to risk

We found that patient care had been planned for emergency care and treatment: the main practice had a well-equipped resuscitation trolley including portable suction, a defibrillator and a range of medical intervention equipment. We saw that all the emergency medicines were within their use-by date and all the equipment had been regularly checked and maintained. The practice had recently purchased a new automated external defibrillator (AED) and all staff had received training in its correct use. All staff had received recent cardio-pulmonary resuscitation (CPR) training and whilst patients were in the building there was always a GP available for emergency situations.

We found that the computer and phone system incorporated an alarm which alerted all staff in the event of an emergency. There were emergency call buttons in each consultation room, should staff need to call for emergency assistance.

We saw that the practice manager organised monthly searches of the records system to identify whether patients had attended the practice for treatment, or for medication reviews, or for scheduled vaccinations. This had ensured that patients were not at risk of missing their appointments.

Medicines management

The practice did not dispense any medicines directly to patients but a small stock was kept in the practice including emergency medicines. We saw that medicines to treat anaphylactic shock that were kept in readiness in each treatment room were within their use by date and had been regularly checked. We found that all vaccines were stored correctly and were within their use-by date. Temperatures for vaccines stored in fridges were recorded and had not exceeded the safe temperature range. However, the safe temperature range was not identified on the recording form for staff. The practice manager agreed to include this on future records.

There was a clear protocol for managing prescriptions and for their safe collection only by the person for whom they were prescribed. We observed staff managing the process for issuing prescriptions and found this was safe and that essential checks were made at every stage. A staff member demonstrated that repeat prescription requests were checked when patients requested these and that these included controlled drugs.

Five patients we spoke with told us they found it straightforward to obtain a repeat prescription and informed us that their medication had been reviewed by a GP within the previous six months. Patients told us they had not experienced any difficulty with their medicines and that they had felt confident about discussing their medication and repeated use of medication with their GP.

Cleanliness and infection control

Patients told us that they found the practice to be clean. We found the practice was visibly very clean and tidy. There was hand gel available for staff and patients to use at the entrance to the practice.

Are services safe?

There were effective arrangements in place to ensure that patients and staff were protected from the risks of acquiring health care associated infections and that the relevant guidance and codes of practice on infection control were followed. The practice was cleaned daily according to a schedule and we saw that all areas appeared clean and uncluttered. There were also appropriate arrangements for the management, storage and collection of clinical waste.

We read an infection prevention control policy and the practice had a nominated infection prevention lead. The policy covered communicable diseases, dealing with spillages, inoculations, blood borne illnesses, handling samples, clinical waste, management of sharps and basic hand washing. The policy identified a safe procedure for obtaining, storing and transporting samples. However, not all parts of the policy had been updated since November 2010.

The consultation rooms were equipped with personal protective clothing that was easily accessible to staff to ensure that patients and staff were protected.

Staffing and recruitment

We looked at the recruitment records for seven members of staff and found that Disclosure and Barring Service (DBS) checks had been completed. We saw that safety measures were integral to the recruitment applications by including a self-declaration about any criminal convictions.

We saw evidence that the recruitment interview process was carried out and that any gaps in working histories had been discussed with applicants to ensure that the recruitment process was safe. Through these strategies the practice aimed to ensure that only suitable and appropriately qualified staff were employed.

Dealing with Emergencies

The practice had a business continuity plan. The provider had arrangements to relocate the surgery in the event of a major incident by making use of their branch surgery.

Equipment

We found the premises were safe for patients. All portable electrical appliances had been tested within the last year and the lifts in the main surgery and in the branch surgery had been appropriately maintained. Fire safety equipment and alarms had been regularly checked for sound working order, although there was no evidence that a fire evacuation drill had been carried out. Staff informed us they had been instructed about fire safety and evacuation and that they carried out weekly checks of the fire alarm to ensure that it was in working order.

Emergency call systems in toilets in both buildings were in place, although the pull cords were out of easy reach for most people. We informed the practice about this when we provided feedback at the end of our inspection visit.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. There were procedures in place for providing good treatment and care that was in line with national standards and guidelines. Patients were well informed about their condition and had been included and involved in their care. Consent was obtained and care and treatment was discussed with patients in order for them to make informed decisions about their options and lifestyle choices and self-management of their condition.

The practice had health promotion and prevention systems in place, and was effective at monitoring, managing and improving outcomes for patients. There was an effective system in place to manage the health reviews of patients with long term conditions and in relation to patients who were receiving care at the end of their lives. There were effective links and collaborative working with other health and social care providers.

Staff had training that they needed to carry out their roles effectively and this had ensured that patients received appropriate treatment from suitably skilled staff. All staff were supported and were appraised annually.

Our findings

Promoting best practice

We looked at the provider's consent protocol and found this provided clear and concise instruction about the consent to be obtained. It instructed staff to consider the use of drawings and interpreters to aid understanding if this was required. It also outlined when consent would be needed and at what level it would be required for different kinds of treatments and procedures. This meant that staff were aware of the use of consent and of the importance of consent as part of a patient's treatment planning.

For patients who were under 16 years of age, the practice used guidance for the use of the Gillick competency test. This test is used to determine if the patient is able to understand the information given to them about treatment and to make their own decisions about consent.

All clinical staff we spoke with had a robust understanding of consent and the Mental Capacity Act (MCA) 2005.

The practice's provision of an ultrasound suite and access to an onsite physiotherapist enabled patients to have access to immediate diagnostic testing and to rehabilitation services. One GP described how this had enabled patients to benefit from quicker referrals to hospital consultants and receive hospital treatment earlier than they would if the practice did not have their own ultrasound equipment.

The GPs we spoke with told us that at their clinical meetings they discussed changes to guidance and best practice issued by, for example, the National Institute for Health and Care Excellence (NICE) for the NHS. We saw the agenda for clinical meeting had included these topics for discussion. This ensured that the medical staff were aware of such developments that affected the way they assessed and delivered care and treatment.

We found that the practice's approach to promoting best practice according to established NICE quality standards for the treatment of patients receiving end of life care and their families were met.

Management, monitoring and improving outcomes for people

We found that the practice was making use of reference data collected by the NHS in order to gain an insight into the effectiveness of the practice. This information was

Are services effective?
(for example, treatment is effective)

taken from the Quality and Outcomes Framework (QOF) system which is the national data management tool generated from patients' records that provides performance information about primary medical services.

We found that the practice was aware of its performance within its Clinical Commissioning Group area (CCG) and worked to improve this. The surgery was currently in the upper quartile for Quality and Outcomes framework data (QOF) across each of the four domains that show the clinical, the organisational, the additional services and the patient experience set of indicators.

Staffing

The training chart for administrative staff included a variety of training courses such as manual handling, health and safety, fire safety, safeguarding vulnerable adults and children and cardio pulmonary resuscitation.

A staff training chart had not been completed for clinical staff and we were not able to establish a clear overview of what training had been identified by the practice for their clinical staff. However, we found that clinical staff had self-managed most of their own training and had kept up to date their continuous professional development. Training that clinical staff had undertaken included specific training, such as safeguarding children and vulnerable adults from abuse, learning disabilities infection control, obesity, diabetes and respiratory failure.

We saw that arrangements were in place to ensure that all clinical staff were revalidated in accordance with their professional registration by means of continuing professional development. For example, the practice nurse was supported to receive annual updates in key aspects of their role, such as immunisation, by means of study days. Five of the practice GPs were in the process of professional revalidation with the General Medical Council (GMC). One GP had recently completed their revalidation. The three nurses had ensured their continuous professional development and registration status which meant that patient were receiving safe and effective care and treatment.

We saw a sample induction pack for administration staff that offered staff an in-depth induction in regard to the service and their roles and responsibilities. The two administration staff we spoke with confirmed that they had undertaken a thorough induction. When we spoke with a clinical member of staff they told us that although they did not have an induction pack, staff had informed them about housekeeping arrangements and they were in the process of reading all of the policies and procedures. They said they felt supported by their nurse colleagues and the GPs and that if they needed any clinical advice or assistance GPs were always available to help.

We observed that where a GP had a particularly complex consultation, they were assisted by another GP, in order to provide support. They told us this had made them feel supported.

An effective annual appraisal process was in place. We saw annual appraisals that showed that the practice manager had undertaken appraisals with three administrative members of staff. The practice manager told us that the partners of the practice were responsible for undertaking nurses' annual appraisals. We saw copies of two nurses' appraisals, which gave a summary of the appraisal, the staff member's roles and responsibilities and the quality of their practice and clinical care. Action points had been developed for these staff to follow throughout the year. This process was also implemented for all other non-clinical staff who were appraised by the practice manager.

One member of staff commented that more frequent monitoring of performance would be welcomed. Although we found that staff were suitably trained and were providing effective care and treatment to patients, there were no other formal and more frequent supervision arrangements for nursing staff apart from their annual appraisals.

We saw that where complaints raised by patients related to staff, this feedback was incorporated into their learning needs and appropriate action taken and support given.

Working with other services

We found that the practice had worked with the City of Lincoln Council by promoting a healthier lifestyle service and had referred a significant number of patients to a healthier lifestyle service. We saw that the practice had been presented with an award for their efforts and for providing patients with information and making referrals to this local service.

We saw evidence of instances of collaborative working that ensured a safe standard of care was provided for different patient population groups. One doctor we

Are services effective?

(for example, treatment is effective)

spoke with explained how information was shared with community nurses and social care teams during the monthly multi-disciplinary meetings about patients who were receiving palliative care and those with long term conditions. We saw that patients' records reflected decisions made at the regular multi-disciplinary palliative care meetings. We also saw evidence that patients' care and treatment had been made in collaboration with mental health services and local authority social care teams and independent service providers.

We found that when patients had been seen by the out of hours GP services, this information had been immediately recorded by the practice in patients' records, as soon as they had been made aware of this. This ensured staff knew the most up to date information about their patient's health care. Overall, the records ensured there was detailed information that informed GPs and nurses within the surgery about patients' health risks and whether there were any safeguarding risks. We saw examples of where the GPs had worked collaboratively with health visitors and shared information with the Local Authority Children and Family teams about children who were at risk.

We also saw evidence that GPs worked with three local residential care services which had ensured that these patients received regular visits from GPs.

Health, promotion and prevention

The practice used a working record of the patient profile that had enabled them to identify and provide support to patients who were in need of end of life care, those who had a long term condition, were diabetic, those due for cervical screening, or due for a medication review. We saw that the practice participated fully in screening programmes for the prevention of long term conditions for particular groups, such as cervical cancer screening.

We saw that health promotion information was displayed in the main surgery and in the branch surgery and this included advice on smoking cessation, obesity, immunisation and diabetes and different types of cancer. We were told that this display area was updated weekly with different health promotion information.

New patients had been offered an assessment to ascertain details of their medical and family histories, their lifestyle, medication and risk factors, such as smoking and alcohol intake, blood pressure, and body mass index. Two patients we spoke with, who had recently registered with the practice, confirmed their first consultation had been thorough and their healthcare and lifestyle had been assessed and discussed.

Two parents told us that they and their children had received health assessments in line with the expectations of the Healthy Child Programme, a Department of Health expectation for standards of healthcare during pregnancy and the first five years of childhood. We asked the nursing staff about their childhood vaccination programme. They told us that all nursing staff gave childhood vaccinations and there was a robust system in place for following up those children who had not attended for their vaccination.

We saw that the care patients were receiving at the end of their lives was monitored by means of a multi-disciplinary team (MDT) meeting involving the doctors, the practice nurse, the community nursing team and the Macmillan service. Each person receiving palliative care had an end of life care plan. The purpose of the monthly team meetings was to discuss each person and to make alterations to their care plan based on their evolving needs. The MDT meeting also discussed each person's death after they had passed away to review whether their care plan had been effective. We looked at the anonymised records of a number of these meetings and saw evidence of how this had worked.

Are services caring?

Summary of findings

The practice was caring. Patients were treated with respect and compassion by staff. We saw examples during our inspection of patients being treated with respect, dignity, compassion and empathy by staff.

Patients spoke positively of their experiences and of the care and attention offered by the staff.

Patients receiving mental health care and treatment and patients from ethnic minorities were shown particular consideration. Patients receiving end of life care were provided with personal care by the GPs at the practice.

Our findings

Respect, dignity, compassion and empathy

All of the 25 patients we spoke with reported they were happy with the care they received and felt that clinical and administrative staff treated them with dignity and respect.

We observed that patients were spoken to in a polite and kindly manner by the reception staff when they arrived at the practice. We noted that conversations between staff and patients were subdued and showed that patient confidentiality was considered and upheld. We saw the same polite attitude prevailed when nurses and GPs spoke with patients.

We observed the interaction between a GP and the family member of a person receiving care. The GP was understanding, empathetic and listened to all of the person's concerns. The GP was supportive to the person and allayed many of their concerns.

Each treatment room included privacy curtains to ensure patients' dignity and privacy was upheld.

There were signs in the waiting areas that informed patients that chaperones were available during consultations of an intimate nature, should patients request this. One nurse informed us that they had received training for this role.

We saw a range of information available in leaflet form in the reception and waiting areas about different health topics although the literature was all in English. However, we noted that patients could gain access to written information online in different language formats if their first language was not English.

When a person's relative had recently deceased the practice would contact the family to offer condolences and support for any social care needs and benefits and funeral planning.

Involvement in decisions and consent

Most people we spoke with told us that they felt involved in decisions relating to their care and treatment. They told us that treatment options were explained and consent was obtained. This meant that they could make an informed choice about treatment.

Clinical staff we spoke with had a good understanding of consent and how to apply it. Clinical staff gave us examples

Are services caring?

of where they had used a competency assessment and where they had acted in the best interests of patients without the capacity to consent. Clinical staff spoken with told us about the appropriate documentation that needed completing for these patients. We saw that guidelines that relate to treatment to under 16 year olds and their competency to make decisions about treatment had been followed.

The practice leaflet offered patients a good range of information about the service. It outlined issues such as the telephone appointment systems, the criteria for home visits, registration of new patients and the different clinics which were on offer at the service.

The staff at a care homes we spoke with confirmed that staff from the practice sought consent from patients. This showed that decisions concerning treatment needed to be made in the patient's best interest were done appropriately.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. There was an appointment system that ensured that patients were offered an immediate appointment for urgent cases. The practice had increased its patient population and had met the needs of specific patient groups within its local population, such as patients from ethnic minorities.

The practice had accessible emergency appointments and prescription arrangements and was accessible to people with limited mobility, or whose first language was not English. However, several patients reported they had to wait too long for a routine, or non urgent appointments and had experienced delays when accessing the practice by telephone.

There was a clear complaints policy and patients' complaints had been consistently responded to in a thorough and attentive manner.

Our findings

Responding to and meeting people's needs

We saw staff had access to an interpretation service should they need this to enable communication with people whose first language was not English. This service was in the form of a telephone translation service which staff had access to at any time of the day. The provider's website also included translated information in six other languages about registering with the practice.

Information about the practice was available in Polish and that had been chosen because of the numbers of Polish speaking patients registered with the practice. We observed and were informed that that one member of reception staff was able to communicate very effectively in three languages. We saw that this member of staff was frequently engaged in conversations with non-English speaking patients. This showed us that these patients were receiving appropriate information about the service and treatment.

Staff showed us a communication book of pictures they could use to support patients with a learning disability. This provided useful pictures and information to patients in a way they may understand. There was a guide to useful Makaton signs (a language programme using signs and symbols for those who find it hard to speak), pictures of symptoms, pain levels, procedures and body parts. This meant that people who communicated via these methods were supported to do so. For people who had a hearing impairment, we saw that the service had a portable hearing loop, should this be required. This meant that people would be enabled to hear what was being said to them more easily.

The practice had its own ultrasound suite and a physiotherapist on site two afternoons per week. This enabled patients to have access to diagnostic tests and rehabilitation quickly. On GP told us about a patient who had attended for an ultrasound appointment during our visit. As a result the GP had been able to make a hospital referral straight away. A nurse told us that this service is a more personal service and reduces hospital waiting times and that the practice has more control over this process.

One patient told us they were pleased with the care they received and had not experienced any difficulty with several referrals to hospital that they had needed. They told

Are services responsive to people's needs?

(for example, to feedback?)

us the practice had made a very prompt referral to hospital for them, which had resulted in immediate hospital treatment. This showed that the practice supports patients to receive a timely and accurate diagnosis, either directly from the practice or by referral to an appropriate specialist.

We found that the appointments system had a built in flag alert for reception staff, so that where a patient required a longer appointment this was accounted for in the booking of appointments.

People received support from the practice following discharge from hospital. When the practice had received discharge reports from hospitals when patients had been discharged, they were followed up by the GP making a home visit to the patient.

Access to the service

The General Practice Outcomes Standards (GPOS), which is an NHS tool for General Practices to record achievement, identified that patients had a low satisfaction rate when asked about access to the service. We saw that the practice's patient survey showed a significant number of patients thought the practice was not open at times convenient to them. We found that the practice had extended their opening times in response to these patients' views.

13 patients we spoke with and the representatives of the patient participation group told us that the telephone answering process and being able to speak with a member of staff were always difficult. We were told that it was usual for the phone not to be answered and that patients were left waiting at every connection option offered by the practice. We tested this and found that on three occasions of trying to speak with a person there was a delay, or there was no reply from the selected options that were available.

The majority of the 25 patients we spoke with told us they had always been offered an appointment with a GP or a nurse. This demonstrated that appropriate requests for same-day appointments were met.

We found there was a system for booking daily emergency appointments and that a duty GP was available every day for emergency appointments, as well as those scheduled for other GPs. The practice manager monitored the appointment system to ensure that reception staff used a written protocol to ask a series of questions to help determine the urgency of the patient. We saw that non-clinical staff did not discuss or give an opinion about any patient's health. This demonstrated that the appointments system was monitored to check how the appointments system and open-access system worked.

Information was available at both locations in a few languages and formats for patients, for whom English was not their first language. The main practice had a touch screen appointment login device that gave the option for English and Polish. The practice's website used a translating programme for a large number of languages. The GPs, nurse and reception staff we spoke with told us that the significant Eastern European community had been discussed at practice meetings so that all staff were aware that the practice could provide information in different languages. We also saw evidence that this had been discussed in the patient participation group where they tried to involve more patients whose first language was not English.

We were informed by two Polish patients, who had moved to the area recently, that they had found it easy to register with the surgery and that they had friends who were also registered at the surgery.

We found that patients with a disability had reasonable access to the practice. We saw there were suitable ramps for people who use a wheelchair and for parents with prams and pushchairs.

Concerns and complaints

During the inspection one patient approached the reception desk to make a complaint. Staff listened to the person's concerns and dealt with the issue in a calm and respectful manner. We asked for a summary of the complaints people had made to the provider. We found that when these had been received that the practice manager had dealt with them appropriately and in line with the complaints procedure. There was evidence that they had responded to the complainant to ensure that issues of concern were resolved to their satisfaction. The practice also made improvements as a result of complaints. For example, we were informed by two patients that their requests to see only a female GP had been responded to and the surgery had allocated them to a female GP.

There was an effective complaints system available for patients in the surgery and on the website. We found the complaints policy and procedures were clear, in-depth and

Are services responsive to people's needs?

(for example, to feedback?)

covered areas such as the core values and visions of the location and the action staff would take to prevent any re-occurrence following a complaint. The policy also outlined the timescales for response so that patients were aware when they would expect and outcome to any complaints made.

Are services well-led?

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

Summary of findings

The practice was well led. There were effective governance structures which included regular communication both within and external to the practice.

The practice made use of information acquired directly from patients and information held electronically to manage and improve the provision of its services.

It was unclear what actions the provider had taken when audits had been carried out.

The practice was supportive of staff development and of patients' views. Staff and members of the Patient Participation Group (PPG) were supported and listened to by the practice.

Our findings

Leadership and culture

One GP told us that they had established the practice with an aim to provide high quality, person-centred care. This approach to care was reflected throughout our discussions with the three GPs we spoke with and we saw evidence that this philosophy had been realised. For example, members of the Patient Participatory Group (PPG) we spoke with during our visit told us that the practice was very supportive of their group and they had frequent meetings with the practice so that patient views were represented. We found that the practice had responded to a request from the PPG and had arranged training for staff and for the group to be more aware of equality and diversity matters. This showed that the GPs' ethos for providing good care and treating people with fairness had been put into practice.

All of the members of the staff team we spoke with during our inspection told us that they shared the GPs' vision for providing good quality care and of treating people with respect and fairness.

Governance arrangements

We found that staff were aware of their own roles and responsibilities and that some staff members had designated lead roles for different aspects of the practice's business. This included roles such as safeguarding lead and infection control lead.

There were regular practice meetings that enabled decisions to be made about issues affecting the general business of the practice. The practice held monthly clinical meetings involving the GPs, nurses and the practice manager where decisions about clinical issues were discussed and resolved. This included issues that arose from reviews of data about patients held on the records system. We saw that one meeting had identified the need to investigate frequent attendances at the hospital trust accident & emergency department. We were told by a GP how this had been followed up by them when they had visited the hospital and investigated the circumstances. We saw that as a result changes had been made to create a more flexible emergency appointment system.

Are services well-led?

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

Not all practice or clinical meetings had been recorded. This meant that information relating to improvement actions might not be easy to retrieve and actions could not be accounted for from meeting to meeting.

We found that clinical audits had taken place for high blood pressure monitoring and use of medication, and nursing management of patients with venous leg ulcers and obesity and Chronic Obstructive Pulmonary Disease (COPD). Medicine audits for emergency drugs stored at the premises and audits in regard to vaccine and immunisation expiry dates had also been carried out. We saw that an infection control audit had taken place in April 2012 although there was no evidence that one had taken place since. The audit had raised some areas for improvement, although there was no record of an action plan to address these issues. Repeat prescription requests that included controlled drugs, were checked at the point of request for any risk of over-prescribing, although there was no evidence to show that prescribing had been audited.

Systems to monitor and improve quality and improvement

There was a system to evidence that the surgery had responded to complaints. We found that the practice had acted on issues raised by patients, such as ensuring that a female e GP was available for patient who had requested this.

We saw that the provider had carried out an audit of the ethnicity of their patient population and had planned to improve their interpretation service. They had also responded by employing one staff member who was fluent in three languages, which had improved communications for a number of patients.

We found that the higher than average attendance rates by patients at hospital A&E departments, reported in the General Practice Outcomes Standards (GPOS) had been responded to by the senior partner GP. Whilst there was no recorded evidence about the action taken by the practice, they had subsequently increased the number of available urgent appointments for patients.

We read evidence of the monitoring of patients who did not attend their appointments and that action had been taken to remind patients of their appointments and to increase the number of available appointments.

Patient experience and involvement

The provider offered patients the opportunity to have a say about the service they received. The provider had collated all of the results from the last patient survey, had responded to these and formulated an action plan to address any improvements which they felt were necessary.

There were regular meetings and communication between the patient participation group (PPG) and the practice. This had facilitated a greater understanding of some issues they had reported, such as the difficulties about telephone access to nurses and GPs and the need for improved language services for non-English speaking patients. We saw that these issues had been acted on by the practice and this showed that the practice had processes in place for engaging with people using the service and for acting on their feedback.

Staff engagement and involvement

Staff members we spoke with told us that they felt valued by all of the senior team at the practice and that their views were listened to. We saw evidence e during our visit that the practice manager had an 'open door' policy to discuss any areas of concern or suggestions at any time.

Staff meetings had been recorded to indicate what staff had discussed. We saw that clinical meetings were taking place, although there were not any minutes of these meetings kept other than the agenda that had been discussed. This meant that the provider was not able to account for the way that decisions had been made about key issues that affected the way the practice was run.

Two members of staff told us they were encouraged to raise concerns and to whistle blow should the need arise. They told us they were confident they would be supported through this process.

Learning and improvement

We found that there was a focus in the practice on learning from events and the use of clinical audits to drive improvements. Staff told us how they had discussed as a team an issue that had been identified in an audit and how they had implemented a change to the issuing of repeat prescriptions. Clinical staff we spoke with gave us an example of where several palliative care issues had been discussed at multi-disciplinary team meetings and this had enabled them to improve the care provided.

Are services well-led?

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

Identification and management of risk

The practice had a patient profile risk tool that they used to identify patients at heightened risk of re-hospitalisation and with long term conditions. They used this to look at any recent hospital treatment patients have had and to ensure patient treatment was reviewed.

They had also used a survey to investigate attendances at the hospital trust's emergency department.

In addition, the practice had systems in place to identify and manage the risks to patients associated with the level of staffing and their skill and the cleanliness of the environment.

We observed that the reception desk was short staffed throughout the duration of our visit, although the main reception staff were supported by colleagues. There were periods when we observed a number of patients waiting to speak with the one reception staff who also had the responsibility to speak with some patients in their native language. Although the staff worked hard and diligently to support the reception staff, this was reactive to the numbers of patients arriving, rather than a proactive plan to avoid a queue of patients. We were informed that the practice had responded to this and had advertised for another reception staff to resolve this problem for patients.