Poole Road Medical Centre

Quality Report

7 Poole Road
Bournemouth
Dorset
BH2 5QR
Tel: 01202 761120
Website: www.pooleroadmedicalcentre.co.uk

Date of inspection visit: 06/05/2015
Date of publication: 09/07/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Poole Road Medical Centre on 6 May 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, responsive, well-led and effective services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and addressed;
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks and management of medicines;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment;
- The practice provided patient's a printed copy of their summary care record to take with them to A&E;
- Information about services and how to complain was available and easy to understand;
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day;
- The practice had good facilities and was well equipped to treat patients and meet their needs;

Summary of findings

- There was a clear leadership structure and staff felt supported by management;
- 80% of respondents to a national patient survey said their overall experience of the practice was good;
- Poole Road Medical Centre is also a training practice for doctors training to be GPs and medical students; and
- The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it in 2013/14 they had met 98.4% of the outcomes. This was higher than the national average for GP practices.

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

Importantly, the provider must:

- Carry out disclosure and barring service checks or risk assessments for staff who performed chaperone duties;
- Prescription forms must be logged and tracked through the practice;
- Ensure patient group directions are authorised by a clinician; and
- Ensure staff recruitment checks follow current legislation.

In addition the provider should:

- Ensure records of staff appraisals are kept;
- Operate a programme of clinical audits; and
- Ensure toys kept at the practice are included in cleaning schedules.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Systems and processes were not consistently implemented which placed patients at risk of harm. Areas of concern included management of medicines and staff recruitment.

Are services effective?

Good

The practice is rated as good for providing effective services

Care and treatment was delivered in line with best practice guidelines. Significant events were taken seriously and were responded to in a timely manner. GPs and nurses were able to prioritise patients and make use of available resources. The practice provided its patients with a wide range of information about health promotion in its waiting area and on its website. Staff had annual appraisals and told us that their training needs were supported by senior staff. We found records were not always kept.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. This was further evidenced during our observation of staff and patient interactions and discussion with members of staff about the way they provided practice to their patients. The practice carried out satisfaction surveys of the virtual patient representation group and the results generally showed a positive patient attitude towards the practice and the service staff provided.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services.

Poole Road Medical Centre reviewed the needs of their local population to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an open culture within the organisation and a comprehensive complaints policy. Complaints we looked at were investigated to a satisfactory conclusion for the patient.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity.

The practice proactively sought feedback from patients and had an active patient representation group.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

The practice had a high prevalence of patients aged over 65 years old and in addition had a high number of patients who resided in care homes.

The practice employed a clinical specialist to support patients who were over 75 years old. This staff member had a particular focus on patients with long term conditions and those at risk of hospital admission. The role involved managing care plans for over 200 patients over 75 years old. The practice provided an in house ward round at the largest of the local care home along with home visits for all patients that needed to see a GP at home. In addition to these measures the practice also provided a quick access telephone number for those vulnerable older patients or their carers to use to access the practice in times of emergency.

People with long term conditions

Good

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

The practice offered nurse clinics for patients with respiratory disease and those with diabetes. There was a robust recall system for the management of chronic diseases.

Patients with long term health conditions were offered structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

The practice offered a same day appointment clinic between 4pm and 4:30pm to improve access for children of school age and reduce the need for them to take time out of lessons.

The practice manager worked closely with a local primary school, St Michaels to have a joined up approach to the health and social care needs of the children, the majority of who were registered with the practice.

Safeguarding concerns were actioned appropriately. A named safeguarding lead coordinated these and received regular

Summary of findings

multi-agency safeguarding reports and made relevant staff aware of any concerns raised about any of their registered children or families. This enabled the practice to support the family or young person where needed.

Working age people (including those recently retired and students)

Good

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

The practice offered extended hours on one morning a week and one Saturday a month in an effort to improve access for working age people. It engaged with the NHS programme of health checks for patients over 40 years of age to support them with early interventions to reduce the long term risk of chronic disease and provided general health education. Access to GP advice was provided through telephone consultations and on-line services were available to book appointments or order repeat prescriptions.

People whose circumstances may make them vulnerable

Good

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

The practice maintained a vulnerable patient list and had regular meetings which included staff from social and community services to review patients' health and social care provision. Staff worked the local Big Issue office to provide effective care in addition to that offered by the homeless GP service to those vulnerable persons with no fixed abode who had long term or more complex health conditions. This continuity of care enabled this group to manage their conditions and improve their quality of life.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

The practice maintained a register of all patients who had ongoing mental health conditions. Staff closely monitored these patients to ensure that their conditions were well managed. In addition the practice also employed its own counsellor who it could provide rapid access to for those patients who required urgent care and where a quick intervention by a professional could prevent deterioration in mental health.

Summary of findings

What people who use the service say

During our inspection we asked 18 patients to tell us about their experience of using the practice. Questions we asked them included ease of making an appointment, practice opening hours, privacy and dignity, trust in the GP, cleanliness of the practice and whether patients would recommend the practice to someone who moved to the area.

The majority of patients were very positive about their experiences of care and treatment at the practice. All of the 18 we asked told us that their privacy and dignity was respected by staff and they had confidence at trust in their GP.

All but three patients said they would recommend the practice and all 18 said the practice was clean and hygienic. However one of the respondents commented that they were not happy with the cleanliness of a patient toilet. We found all the toilets clean on the day of our visit.

We also received three comment cards which were completed before the day of our inspection. All the comments were positive and told us that the practice staff were efficient, caring and compassionate.

There was a virtual patient representation group (PRG) in place and this group were asked for their feedback by completing surveys. Requests for volunteers to join the PRG were advertised through the practice website.

We also looked at the results of the most recent patient survey carried out by the practice in 2014.Results of this included:

- 90% said they were satisfied with the service Poole Road provided
- 100% said they found the building welcoming, clean and easily accessed
- 100% found staff to be friendly

Areas for improvement

Action the service MUST take to improve

- Carry out disclosure and barring service checks or risk assessments for staff who performed chaperone duties.
- Prescription forms must be logged and tracked through the practice.
- Ensure patient group directions are authorised by a clinician.
- Ensure staff recruitment checks follow current legislation.

Action the service SHOULD take to improve

- Ensure records of staff appraisals are kept.
- Operate a programme of clinical audits.
- Ensure toys kept at the practice are included in cleaning schedules.

Poole Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

The team included a GP specialist advisor and practice manager specialist advisor.

Background to Poole Road Medical Centre

Poole Road Medical Centre is situated in Poole Road, Bournemouth.

The practice has an NHS general medical services (GMS) contract to provide health services to approximately 8400 patients.

The Practice offers walk-in appointments every weekday morning between 8.15am and 10.20am. These are for both routine and emergency needs. Afternoon and telephone appointments are available with all the GPs and these can be booked in advance. The practice also holds early morning surgeries on Tuesdays between 7.30am and 8.00am and on one Saturday a month between 8.30am and 12.30pm. The practice has opted out of providing out-of-hours services to its patients and refers them to Dorset and Somerset Urgent Care Services via the 111 service.

The mix of patient's gender (male/female) is almost half and half. The practice has a considerably higher number of patients aged between 25 and 34 years old and patients over 75 years old when compared to the England average.

The practice has a high number of patients who have a long term condition and are in receipt of disability related benefits when compared to the England average and is situated in an area of high deprivation.

The practice has four GP partners and two salaried GPs. In total there are three male and three female GPs. The practice also has three practice nurses and two health care assistants. GPs and nursing staff are supported by a team of 16 administration staff. The practice administration team consists of receptionists, secretaries, a reception supervisor and the practice management team. Poole Road Health Centre is also a training practice for doctors training to be GPs and medical students.

We carried out our inspection at the practice situated at;

Poole Road Health Centre

Poole Road

Bournemouth

BH2 5QR

Why we carried out this inspection

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

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

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website and NHS National GP Patient Survey.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with patients who used the practice. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

For example, an abnormal blood result received at the practice was forwarded to a GP registrar for attention. Unfortunately the registrar was away from the practice and the results were not redirected to the duty GP in the same way other GPs results were. The practice changed its protocol to included registrar GPs into its information forwarding system.

We reviewed safety records, incident reports and minutes of significant review meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these.Significant event meetings were held as and when required to agree actions required and a log was kept to review actions from past significant events and complaints to ensure the practice processes were effective and minimised risk of harm to patients.There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, following a patient collapse in a public area of the practice a second privacy screen was purchased and seen to be easily available should an occurrence happen again which required a patient to have their privacy and dignity respected.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Staff used practice specific template forms on the practice intranet and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked ten incidents and saw evidence of action taken as a result. We saw evidence that staff were involved in resolving an incident and taking necessary action to prevent it occurring again. For example, a member of staff's telephone call taking style was identified as requiring improvement and training was given to resolve this.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were cascaded by the prescribing lead GP to relevant staff for action.

Staff gave examples of recent alerts that were relevant to the care they were responsible for and where they needed to take action. For example a recent alert for Domperidone (an anti-sickness medicine) was received. Evidence seen confirmed that the prescribing lead identified all the patients who were taking this and their named GP was informed and action as a result of this included telephoning or writing to the patients and adjusting their prescribed dose.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that five out of seven GPs and four out of five nursing staff all staff had received relevant role specific training on safeguarding children. All but three administration staff had also received level one safeguarding children training.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and available on the practice intranet.

A GP partner was the safeguarding vulnerable adults and children lead. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and would contact them if they had a safeguarding concern.

Requires improvement

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example, patients who were subjected to domestic violence and at risk children had alerts on their electronic patient records. We were shown two specific anonymised patient records which confirmed this. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Health visitors were based at the practice and we saw examples of good communication with them and the GPs.

There was a chaperone policy and signs offering the service were seen in every consulting and treatment room. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

Records provided to us before our visit showed that four nursing staff had been trained to be chaperones. During our visit we were made aware that four reception and administration staff performed chaperone duties and these staff had not received training for this role. Neither the trained or non-trained staff had received disclosure and barring service checks.

Medicines management

We checked medicines stored in the treatment rooms and the practice's medicine/ vaccination refrigerator. Access to these was only accessible to authorised staff.

There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. And expired and unwanted medicines were disposed of in line with waste regulations.

Medicines administered by the nurses at the practice were given under a patient group direction which is a directive agreed by GPs which allows nurses to supply and/or administer prescription-only medicines. However, we found on inspection that of the thirteen directions we examined, two were signed by a GP partner, six were not signed at all and five had only been signed by the practice manager. Legal requirements state that a direction must be authorised by a clinician.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms were signed for on delivery and then handed out to GPs when requested but these were not logged. Prescription forms were kept secure in the practice during surgery hours. For example, GPs rooms were locked when not in use. However, blank prescription forms were not removed from printers overnight which made them accessible to unauthorised people.

Cleanliness and infection control

We found the premises to be visibly clean and tidy. We asked 18 patients if they would say the practice was clean and hygienic. Of these, 15 told us they would definitely say the practice was clean and hygienic and three said they would probably say this too. We received one less positive comment about a patient toilet in the waiting room but found this to be clean and tidy during our visit.

We saw there were cleaning schedules in place and cleaning records were kept by external cleaners who also carried out weekly checks of the standard of cleaning carried out. Nursing staff had cleaning schedules but these were not used. We saw records to confirm that the treatment/consulting room patient modesty curtains were replaced regularly. The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training in 2014. All staff received training about infection control specific to their roles in the previous 12 months.

We saw evidence that the practice had carried out infection control audits every six months for the past two years and that any improvements identified for action were completed on time. An audit carried out in April 2015 identified that hand gel sanitising liquid and bin liners for nappy bins in baby changing rooms were missing. We saw that bin liners were present at the time of our visit and was told that secure hand gel dispensers were on order for fitting in the waiting areas.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The policy

had been reviewed in October 2013. The policy included information about cleaning, hand washing, personal protective equipment and sterile equipment handling. An annual infection control statement had been produced in April 2015 which included risks assessments, policy and procedure reviews, staff training and details of any infection transmission incidents.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in patient toilets and above every sink in treatment and consulting rooms. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of such an injury.

The practice had a policy for the management, testing and investigation of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice carried out a Legionella risk assessment in May 2013 and associated testing of water quality.

The practice had a toy cleaning policy which indicated that nursing staff should clean toys daily and ensure that unauthorised toys, such as material toys, were removed. There were no records available to demonstrate this was done. We found three soft (cuddly) toys in a toy basket in the waiting area and the remainder of toys were found to not be particularly clean.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was January 2015.We saw evidence of calibration of medical equipment such as doppler's, nebulisers and refrigerators was tested on January 2015 to confirm it was working effectively.

Staffing and recruitment

The practice had a recruitment policy, dated June 2013, that set out the standards it followed when recruiting staff. Areas included evidence of proof of identity, satisfactory conduct in previous employment and documented reasons for any break in employment.

A clinical advisor started to work at the practice in December 2014. This member of staff supported patients who were over 75 years old. their personnel file only contained a contract of employment. We asked for further evidence of employment checks and was given an email from this person's previous employer which was favourable. Other than this there was no evidence to confirm that the necessary checks had been made to ensure this person was of good character and trained to carry out their role. We asked the practice manager about this, they confirmed that required checks had not been made.

We looked at two more staff files. These staff started to work for the practice in January and April 2015. We found that neither file contained a proof of identity, proof of eligibility to work in UK or evidence to confirm that a Disclosure and Barring Service check or risk assessment had been carried out. There was no explanation of gaps in employment or written evidence of conduct in previous employment.

Three nurses and a health care assistant also worked at the practice. Two of these staff started to work at the practice in 2013. There were no records available to confirm that a DBS check had been carried out for any of them. We spoke to the practice manager about this and was told that DBS checks were currently in the process of being carried out despite these staff being employed since 2013 when these checks became mandatory.

The practice also employed locum GPs (a locum GP is a GP who temporarily fulfils the duties of a permanent GP). We were shown recruitment records for two locums and found all the necessary checks required had been carried out prior to them starting work.

The practice had arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. We were told that GPs ran extra clinics on the day following a bank holiday to meet

demand. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice also had a health and safety policy which was reviewed in June 2013 and health and safety information was displayed for staff to see. Records provided to us before our visit showed that 24 out of 28 staff had received health and safety training.

The practice carried out health and safety risk assessments and kept a log. The last risk assessment was carried out in June 2014. Areas of concern identified included the looking of an external fire door during practice hours and the storage of boxes and equipment stored at the bottom of a stairwell which was a means of escape. We saw an action plan that was produced following the assessment and found they had both been addressed to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 20 staff had received training in basic life support in the previous 12 months and 4 had received training in 2012.

All staff had an internal practice panic alarm system on their computers and desk mounted alarms which we were told were linked to the practice's alarm company monitoring centre. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED) (an AED analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff knew the location of this equipment and records confirmed that it was checked regularly and safe to use. Emergency medicines were available in a secure area of the practice and all staff knew of their location. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been reviewed in April 2013. Risks identified included loss of water, gas, electricity, unplanned sickness of GPs or staff and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a gas and heating company to contact if the practice boiler failed.

Risks associated with service and staffing changes (both planned and unplanned) were included in a continuity plan risk log and the mitigating actions had been put in place to manage this. For example, the loss of the telephone system was identified as a high level of impact and risk to patients. The plan detailed actions to follow to mitigate this risk which included raising the fault with the telephone company, alerting local practices and GPs making use of their personal mobile phones.

The practice had carried out a fire risk assessment in November 2014 which included actions required to maintain fire safety. Records showed that 22 out of 28 staff were up to date with fire training and that staff practised regular fire drills. The most recent being in September 2014

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were shown an example of a current guideline about the use of a medicine used to treat a bacterial infection and was told this had been actioned. GPs confirmed that sharing information about best practice guidelines took place d but did not follow any set system and was not documented by way of notes or minutes of discussions held. We were also told that clinical guidelines were reviewed with other local GPs at six monthly meetings held by the local clinical commissioning group (CCG).

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs told us they lead in specialist clinical areas which included skin conditions (dermatology) and contraceptive implants. The practice nurses supported this work, which allowed the practice to focus on specific conditions.

A GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was worse when compared to local practices. We were told this was due to the high number of patients who resided in care homes in the area. This was confirmed by information we held about the practice which showed it had a higher number of registered patients who were aged over 75 years old compared local CCG averages. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. This involved the GP reviewing information about the patient's treatment and deciding on the next course of action required.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients to secondary care services such as consultant led treatment. For example patients with suspected cancers were referred to be seen by a consultant within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us two clinical audits that had been undertaken in the last 12 months. Both of these were completed audits where the practice was able to demonstrate that the system they used was effective and therefore did not require any changes to be made. One audit was about antibiotic prescribing and the other was about polypharmacy (where a patient is prescribed more than ten medicines). Both were documented appropriately but not stored in one central point in the practice. We asked for an audit plan we were told that one wasn't kept.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

For example, we were told about an audit a GP carried out regarding the prescribing of benzodiazepines (medicines used to treat anxiety, sleeping difficulties and other conditions). The GP went on to say following the audit, they carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. However, records of this audit were not available to confirm success of any changes made.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 97% of patients with diabetes had an annual medication review in the previous 12 months of our visit.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that on the whole staff were mostly up to date with attending mandatory courses such as annual basic life support. For example, 17 out of 28 staff had received fire safety training in last 12 months and one member of staff had received manual handling training.

We noted a good skill mix among the doctors with one having an additional diploma in dermatology. We were told they undertook this training as a result of the high number of referrals they made to other services.

GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, diabetes, smear taking, asthma and wound care training was logged in staff files.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The practice was a training practice, doctors who were training to be qualified as GPs had access to a duty GP throughout the day for support. We received positive feedback from the trainee we spoke with who told us they were very well supported.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service either electronically or by post. Staff told us that any paper based information that came into the practice was scanned and added to patient's records. We found that the scanning of these was up to date. The patients' GP or their buddy GP, who saw these documents and results, was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. We were told that this meeting involved the reviewing and updating of patient's care plans but minutes of these meetings were not kept.

Information sharing

The practice used a number of systems to communicate with other providers. For example, the practice made all its patient referrals to other services through the choose and book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital The medical secretary made appointment for patients and posted details of their appointment and instructions about how to change it.

For emergency patients, there was a policy of providing a printed copy of the patient's summary care record for the patient to take with them to A&E. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called EMIS to coordinate, document and manage patients' care.

All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We reviewed data from the national GP patient survey (published in January 2015) which showed the practice was rated below the local and national patient satisfaction average by patients who were asked how good they felt the GP was at involving them in decisions about their care and treatment. Of the patients asked, 70% said they felt the GP was good or very good.

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to

Good

Are services effective?

(for example, treatment is effective)

describe how they implemented it in their practice. Training records provided before our visit showed that 27 of the 28 staff had received mental capacity act training in April 2015.

For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

For example, we saw an assessment of capacity checklist which included a step by step process to assess a patient's capacity to make decisions.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, 24 out of 25 care plans had been reviewed in last year.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a comprehensive and clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. We were told that this was particularly important for the GP who carried out contraceptive implants.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in 90% of cases.

Health promotion and prevention

The practice had met with the local public health team and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that of those patients invited, 17% took up the offer of the health check. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all 24 patients registered were offered an annual physical health check. Practice records showed 96% had received a check up in the last 12 months.

The practice had also identified the smoking status of 90% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 1684 patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 64, which was average compared to neighbouring practices and national figures.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. The practice identified 534 patients who were obese and all were offered support to lose weight. Of these 376 took up support in a number of ways which included exercise referral, reduced cost access to weight management services and where appropriate referral to secondary care services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All but one of the 18 patients we asked during our inspection told us they felt they were treated with dignity and respect by practice staff. The nineteenth patient was neutral in their response.

We looked at the results of the most recent GP patient survey, published in January 2015.

Results showed the practice was rated below the national patient satisfaction average by patients who were asked if they felt GPs and nurses treated them with care and concern. Of the patients asked, 74% said GPs and 64% said the nurses treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received three completed cards and all were positive about the service they experienced. Patients said they felt the practice staff were helpful and considerate. One comment praised staff for always smiling even at their busiest times.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that information was kept private. Consultation and treatment room doors were closed during consultations and conversations that took place in these rooms could not be overheard. Modesty curtains were provided in these rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

The practice switchboard was located away from reception and there was a queueing system which allowed only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. There was also a quiet room available nearby for patients and staff who did not wish to be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was also a clearly visible notice in the patient reception area and waiting areas stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The practice displayed a large range of leaflets and sign-posting documents in its waiting room and on its website. For example, weight loss, counselling and sexual health. This made patients aware of the options, services and other support available to them.

We spoke with staff who confirmed that discussions took place about these options which enabled patients to make informed choices.

We reviewed data from the same national patient satisfaction survey which showed the practice was rated below the national patient satisfaction average when asked if they

were given enough time during their appointment and whether they were involved in decisions about their care and treatment. All but one of the 18 patients we asked during our inspection told us they were involved in decisions about their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language. However we did not see anything to advise patients of this service in the waiting areas.

Patient/carer support to cope emotionally with care and treatment

Staff demonstrated an understanding of the impact a patient's condition/treatment could have on those close to them and were aware of the need to support relatives as well as patients. There was a system for assessing the support needs of carers. The new patient questionnaire asked if the patient looked after someone with a medical condition and if so who and how they were related.

GPs had their own patient lists that meant they had a closer relationship with patients which appeared to work well at times of crisis. Staff told us GPs made contact with the bereaved relative/spouse when they were made aware of the person's death.

Good

Are services caring?

Information and links to counselling support was available on the practice website which included, NHS Counselling, Mental Health, Samaritans, and Cruse Bereavement counselling services. There was also a counsellor based at the practice who saw patients referred by GPs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management and immunisation programmes.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient representation group. For example, the practice re-structured its reception and administration staff's working patterns to ensure that a maximum number of staff were available to respond to higher volume of calls received between 8am and 10am and 3pm and 5pm.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

We observed staff acting in an appropriate way to every patient they engaged with. Staff said they had received equality and diversity training. Training records supplied to us before our visit showed that all but one staff had received formal training in this area.

The practice was accessible to disabled patients and visitors who required level access. We saw three disabled person's parking spaces positioned close to the entrance door. The practice had a wheelchair available for patients who found it difficult to manoeuvre around the practice. There was lift access to the first floor which made movement around the practice easier and helped to maintain patients' independence.

The practice was situated on the ground and first floor of the building with treatment rooms on the ground floor and consulting rooms on the first floor. Wheelchair accessible toilet facilities were available in both the ground and first floor waiting rooms for all patients attending the practice and included baby changing facilities. Treatment rooms were large which made them accessible to wheelchairs and prams. We saw that the ground floor waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment rooms. However, the first floor waiting room was not large enough to accommodate the number of patients waiting to see GPs and we saw a number of chairs positioned in a corridor which was a thoroughfare from the new to the old part of the building.

The practice could not tell us how many of its patients did not have English as their first language but could cater for other different languages through interpreting services, via telephone and there were facilities for patients to translate the practice website into different languages.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website and patient leaflet.

The practice offered walk-in appointments every weekday morning between 8.15am and 10.20am. Afternoon and telephone appointments were also available with all the GPs and these could be booked in advance. The practice also held early morning surgeries on Tuesdays between 7.30am and 8.00am and on one Saturday a month between 8.30am and 12.30pm. The practice's extended opening hours on these days was particularly useful to patients with work commitments and older patients who were taken to the practice by working relatives.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home every week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system and ease of getting through to the practice by phone. We looked at the results of the most recent GP patient survey, published in January 2015. Of the patients asked, 88% said their last appointment was convenient

Good

Are services responsive to people's needs?

(for example, to feedback?)

and 60% said they found it easy to get through to the practice by phone. Both of these were lower than national patient satisfaction averages. We also asked 18 patients about convenience of their appointments on the day of our visit and 12 responded positively but six responded negatively.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy had been reviewed in June 2013 and was in line with recognised guidance and contractual obligations for GPs in England. Information for patients was seen in waiting rooms and on the practice website and leaflet.

There was a designated responsible person who handled complaints in the practice. How to complain information was available on the practice website and in the practice leaflet and on request in reception. However, when we asked 18 patients if they knew how to complain if they had an issue, 11 of the 18 said they did but seven said they were either not sure or definitely didn't know how to.

We were shown a spread sheet which contained seven complaints that were received in the last 12 months. We found that full details of complaints and resulting investigations were kept separately. We saw these had been dealt with appropriately, investigated and the complaint responded to in a timely manner.

The practice reviewed complaints fortnightly at practice meetings and annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. These values were clearly displayed in the reception area.

The practice vision and values included providing highest quality care to patients by making access to GPs as easy as possible, educating and involving patients in the decisions about their care and assisting them to lead a healthy lifestyle through promotion of good health.

We spoke with staff who all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice.

We looked at 20 of these policies and procedures and were told that staff would be emailed to advise them that a policy had been reviewed. We saw examples to confirm that staff was asked to respond to the email to confirm that they had read and understood a policy when it was reviewed.

All 20 policies and procedures we looked at had been reviewed within the last two years and were up to date. We were told that policies were reviewed bi-annually which records seen confirmed. Whilst policies were stored electronically, the review/version date was not included in the written version. Therefore if anyone had a printed version of a policy it would not be clear if it was a current version.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it in 2013/14 they had met 98.4% of the outcomes. This was higher than the national average for GP practices.

We were told that a local peer review system had been set up with neighbouring GP practices. This enabled the practice to measure its service against other GP practices and identify areas for improvement. For example, referring and prescribing.

The practice did not operate a programme of clinical audits and we found these to be ad hoc, however examples of audits seen identified where action should be taken.

The practice had arrangements for identifying, recording and managing risks.

The practice manager showed us the risk log, which addressed a wide range of potential issues. For example, lone working, trip hazards and fire exit safety.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding.

Staff were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open culture within the practice. We were told that although team meetings did not occur frequently staff had the opportunity and were happy to raise issues at any time. However, nursing staff told us they would like to be included in clinical meetings with GPs.

The practice manager was responsible for human resource policies and procedures.

We reviewed a number of policies which included the practice training policy, disciplinary procedure and sickness and absence policy. And found these to be fit for purpose.

We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

We looked at the results of the most recent GP patient survey, published in January 2015. Of those who responded, 72% said they would recommend the practice to someone new to the area. We asked 18 patients about his and 15 said they would recommend the practice, two were not sure and one probably wouldn't.

All the staff spoken with told us they felt engaged with the practice. They also had access to the practice manager and

Are services well-led?

Good

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

told us that they were able to express ideas and concerns. The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

GPs and practice managers met weekly, practice nursing staff told us they did not feel that meetings were required as they all worked closely and communicated informally but wished to meet with GPs at their clinical meetings. Administration and reception staff did not meet regularly and meetings of all the practice staff were held infrequently.

The practice had an active patient representation group who met every six months. The group was made up of 19 patients and supported by staff. A GP always attended meetings and the practice manager supported the group by taking minutes. The practice also had a virtual patient representation group who were contacted time to time by post and email to complete surveys. Patient surveys were carried out face to face, by post and online.

Feedback from a previous survey asked patients about their experience of contacting the practice by telephone. The practice re-structured reception and administration staff rotas to ensure staff were available to handle the calls in a timely manner.

Another change made as a result of feedback was that appointments overran due to patients attending the walk in surgery with a number of ailments but not making a longer appointments in the afternoon where the GP could allocate more time. Patients were requested to only discuss one ailment at the morning walk in surgery and booking an appointment for an afternoon consultation if more time was needed.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

Annual appraisals took place but were not always recorded. Staff told us that the practice was very supportive of training and development opportunities.

A GP trainee told us they felt supported and properly mentored. GPs operated a system whereby a different GP supervised the trainee on a daily rota basis which meant the trainee had a different supervisor every day.There were arrangements in place to manage staff performance. Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care.

The practice took account of complaints to improve the service and significant events were discussed and learnt from.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured that persons employed for the purposes of carrying on a regulated activity were of good character and that information specified in Schedule 3 was available in relation to each such person employed and such other information as appropriate. Checks missing included Disclosure and Barring Service checks, conduct in previous employment, eligibility to work in the UK and photographic identification. Staff that performed chaperone duties did not have either a criminal records check carried out or documented rationale why such a check was not required. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person did not have effective systems in place to monitor medicines. Prescription forms were signed for on delivery and then handed out to GPs when requested but these were not logged. Patient group directions were not signed by a clinician.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person must – Make appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.