Dr S J Brook & Partners

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Brook and Partners at Forton Medical Centre, Whites Place, Gosport, PO12 3JP on 9 December 2014.

Overall the practice is rated as good. It was good for safe, effective, caring and well lead. It was also rated good for all the population groups.. Specifically we found the practice requires improvement for providing safe services.

Our key findings were as follows:

- There was a strategy and track record of continuous improvement for care and responded to the needs of patients living in the area.
- Patients were complimentary about the care and support they received from staff.
- Staff told us they were committed to providing a service that put patients first.
- The practice were aware of concerns related to access to appointments and were working with the patient participation group to improve this.
- The practice was aware of the differing needs of the patients registered with them and was able to provide appropriate care, support and treatment.
- The practice showed good child immunisation percentages, which were in line with the percentage receiving vaccinations across the rest of the clinical commissioning group.
- The practice showed a better than average result in areas such as maintaining a register of all patients in need of palliative care or support irrespective of age and maintaining a register of patients aged 18 or over with learning disabilities. The practice held regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.
- The practice employed an independent pharmacist who worked closely with patients and pharmacies to improve efficiency in prescribing.

Summary of findings

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

Importantly, the provider must: Ensure that all required information is available and satisfactory checks have been made prior to a member of staff commencing employment.

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 requires improvement for safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Areas identified as requiring improvement were communicated widely to all staff members. There were sufficient numbers of staff on duty to keep patients safe. However not all recruitment checks and risks assessments on staff were in place.

Are services effective?

Good

The practice is rated as good for effective. We found that national data showed the patient outcomes were at or near the average for the locality. Patients' needs were assessed and care was planned and delivered in line with current guidance. Staff were able to receive training appropriate to their roles and further training needs were identified and planned for through the appraisal system. Patients who had complex needs, such as those at the end of life, were discussed at multidisciplinary meetings.

Are services caring?

Good

The practice is rated as good for caring. We found that patients were treated with compassion and respect and their privacy was maintained. Patients said they were involved in care and treatment decisions. The practice provided information in accessible formats to assist patients in understanding the care and treatment options available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team and clinical commissioning group to secure service improvements where these were identified. Patients reported that access to the practice could improve, but they were able to be seen on the same day if their concerns were urgent. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this and staff were clear about the vision and their responsibilities in relation to this. The practice

monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The practice proactively sought feedback from its patient participation group and staff and patients and this had been acted upon.	

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 was rated as good for older people.

Patients over the age of 75 years had a named GP and home visits were available if needed. The practice had leg ulcer dressing clinics run by practice nurses who had received specialist training. The practice worked with the integrated care team to provide care in the community and avoid hospital admissions. There were direct telephone numbers for care homes to contact the practice. The practice had also developed links with a local pharmacy to dispense medicines in blister packs, deliver medicines and carry out medicine reviews. Patients who were nearing the end of life were supported by the practice who worked with local palliative care teams and hospices. Gold Standard Framework for end of life care meetings were held monthly with a range of health professionals to discuss patients care and treatment.

People with long term conditions

Good

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

The practice had annual recall systems in place for reviews of patients' conditions and care plans were in place for those patients. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Self-management by patients was encouraged, for conditions such as diabetes and chronic obstructive pulmonary disease. Links had been established with community services, such as diabetic services to support patients in self-management.

Families, children and young people

Good

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

Children aged under one year of age who required to be seen on the same day were seen by GPs. The practice offered immunisations clinics in line with national guidelines. Shared ante and post natal care was offered with midwives and included six week baby checks. The practice liaised with health visitors about any concerns they had over child welfare and held a register of vulnerable children. Contraceptive advice and services were offered to young adults and children.

Summary of findings

Working age people (including those recently retired and students)

Good

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

The practice offered extended hours appointments outside of normal appointment times on Mondays and Fridays. Pre-bookable telephone consultations were available and the practice had an online appointment booking system. The practice liaised with local pharmacies that provided a pharmacy prescription collection service. The practice had a fit note protocol in place for patients returning to work after a period of sickness. NHS health checks in line with national guidance were offered to patients.

People whose circumstances may make them vulnerable

Good

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

The practice had a designated safeguarding lead and staff were aware of how and when to report concerns. Double appointments were available for patients who were vulnerable, such as those living in temporary accommodation. Patients who had a learning disability were offered an annual health check and support was given with decision making when needed.

People experiencing poor mental health (including people with dementia)

Good

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

Patients who had been identified as being in this population group were offered same day appointments to minimise waiting times and refers to other health and care services were made by the practice. The practice had links to counselling services. Patients with a mental health diagnosis had care plans in place and those with dementia were offered tailored health checks.

Summary of findings

What people who use the service say

During our visit we spoke with nine patients, including some members of the Patient Participation Group (PPG) and reviewed one comment cards from patients who had visited the practice in the previous two weeks. The feedback we received was positive. Patients were complimentary about the practice staff team and the care and treatment they received. Patients told us that they were not rushed. They said staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive. We received some negative replies mainly around the appointments system and length of time it took for the telephones to be answered. We spoke with the practice about this and they were aware and were addressing these matters.

The national GP survey showed that 51% of patients would recommend the surgery and 64% considered the practice as good overall. 89% of respondents said they had trust and confidence in the GP and nurses were good at treating them with respect and explaining treatment. Areas identified for improvement from the survey included: seeing their preferred GP; better telephone access and availability of appointments.

Areas for improvement

Action the service MUST take to improve

Ensure that all required information is available and satisfactory checks have been made prior to a member of staff commencing employment.

Outstanding practice

The practice employed an independent pharmacist who worked closely with patients and pharmacies to improve efficiency in prescribing.

Dr S J Brook & Partners

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 and a practice manager. There was also an expert by experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Dr S J Brook & Partners

Dr Brook and Partners is situated at Forton Medical Centre, Whites Place, Gosport, PO12 3JP and currently has six GPs who provide a total of four whole time equivalent (WTE); there are five female and one male GP. In addition there are two nurse practitioners (1.6 WTE), three practice nurses (1.5 WTE) and one health care assistant (0.54 WTE).

The clinical team were supported by an administration team consisting of the practice manager, deputy practice manager, an administration supervisor, reception supervisors and administration and reception staff which made a total of 14 WTE. Cleaning and maintenance was provided by an external contractor.

The practice had approximately 9700 registered patients and provided services under a General Medical Services Contract. These contracts are negotiated nationally with the Department of Health and the General Practitioners Committee of the British Medical Association.

The CQC intelligent monitoring placed the practice in band 3. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice offered routine appointments between 8.30am and 6pm Monday to Friday. On Mondays pre bookable appoints were available from 6pm to 7.30pm and there were early morning appointments on Friday mornings from 7am to 8.30pm. Outside of these times patients were directed to the out of hour's provider.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

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 hold about the practice and asked other organisations to share

Detailed findings

what they knew. We asked the practice to send us information about themselves, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 9 December 2014.

During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, administration staff and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services 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)

This practice shows that the patient age distribution is above the England average for males and females in the 45-79 age groups. The practice indicators show that the average male life expectancy is 77.6 years and female 81.2 years. This practice is shown in the fifth least deprived decile.

Public Health England data showed that 52.3% of patients would recommend the practice. The practice was below the national average for overall satisfaction with service provision, being treated with care or concern by a GP and seeing the same GP.

The practice showed good child immunisation percentages, which were in line with the percentage receiving vaccinations across the rest of the clinical commissioning group.

The practice showed a better than average result in areas such as maintaining a register of all patients in need of palliative care or support irrespective of age and maintaining a register of patients aged 18 or over with learning disabilities. The practice held regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.

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 audit identified that there had been delays in making referrals to secondary care services, such as hospitals. Actions taken included supporting staff and further checks on their referrals to ensure they had been sent. The practice had a protocol in place to ensure that any abnormal tests results were placed on the duty GPs computer screen to manage and follow up when they arrived.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 year and we were able to review these. Significant events was a standing item on the partners meeting agenda and we saw meeting minutes and evidence of follow up actions and on going monitoring which confirmed this. An example we found concerned delayed access to mental health services and one of the GPs had written to the clinical commissioning group highlighting their concerns over the delay.

Significant events were discussed every two weeks at the partners meetings and reviewed at the whole practice meeting twice a year, along with any complaints received. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

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 the majority of staff had received relevant role specific training on safeguarding children and adults. Training had been planned for those who still required it. 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.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three for safeguarding children, and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a chaperone policy, which was visible on the waiting room noticeboard; we were told that only clinical staff acted as chaperones. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were 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. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice held medicines management meetings twice a year and employed an independent pharmacist to review patients who were on several medicines to ensure they were still effective and relevant. We saw records of practice

meetings that noted the actions taken in response to a review of prescribing data. For example, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. The practice had designated staff to manage repeat prescription requests and protocols were followed to ensure the medicines were still relevant and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The cleaning contractors carried out an audit each month and recorded the results. The practice also undertook checks of cleaning carried out, but did not record this.

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. All staff received induction training about infection control specific to their role and received annual updates.

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. For example, 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand gel was also available at the reception.

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 was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. For example, little used outlets such as the staff shower were flushed weekly for at least five minutes and this was recorded.

The practice had designated sharps bins which were disposed of in line with clinical waste management guidelines.

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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

We looked at three recruitment records and found that for one member of staff a criminal records check through the Disclosure and Barring Service (DBS) was in progress, but no other checks such as evidence of conduct in a previous employment had been obtained. The practice had not carried out a risk assessment on this member of staff, but we were told that they never worked unsupervised. All GPs, nurses and health care assistants had had a DBS check, but there were no written risk assessments on why other staff such as administrators had not had a DBS check undertaken. We noted that nurses employed by the practice had checks made on their professional license to practice with the Nursing and Midwifery Council. Other information, such as proof of identity was present in files. We also found that in line with best practice records of interviews were kept.

The practice employed locum GPs and we found that specific checks had been made via the performer's list and confirmation of DBS checks. There was no written protocol in place, but the member of staff responsible was able to tell us what information was needed prior to a locum GP starting work.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

Requires improvement

Are services safe?

meet patients' needs. GPs reported that during the past 12 months the number of partners had reduced from eight to six, which had resulted in some of them working at home after the practice closed, such as checking of results and managing correspondence via a remote link with the practice computer systems.

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, for example portable appliance testing.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice had a system in place which highlighted when equipment and medicines were due to expire, so new ones could be ordered. However, we found that the defibrillator pads for children were a ten days out of date. The practice sought assurances from an expert in resuscitation to establish whether the pads were still safe to use. It was confirmed that it would be safe to use until the new ones which were ordered immediately arrived.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, severe allergic reactions and hypoglycaemia (dangerously low blood sugar levels). 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For example, one GP attended a prescribing meeting organised by the clinical commissioning group (CCG) and disseminated a summary of the latest prescribing guidance via email to the other GPs in practice. Another GP attended a meeting on urology and cascaded info to other GPs on new guidelines. The practice also met with the local commissioning services quarterly to review internal data about care and treatment and outcomes for patients.

The practice achieved a score of 97.1% overall for 2013-14 in its 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, for example diabetes and implementing preventative measures.) These results place the practice above the national average for QOF outcomes.

QOF data showed reviews had been carried out on secondary care outpatient referrals and the practice said they participated in external peer review with other members of CCG regarding referral rates across the area.

The practice also reviewed information on their own emergency admission avoidance register and participated in external review via the CCG on same subject. Care plans had been put into place to avoid emergency admissions and a review of Accident & Emergency attendances was carried out to see if this was effective. When needed improvements were made to the care and treatment provided. These care plans were overseen by an administrator to ensure a GP reviewed a patient's care plan at least every three months and update the care plan if needed.

The senior GP told us that the practice had protocols in place for long term conditions, based on Royal College of General Practitioners Toolkit and there was a strict policy for managing benzodiazepines to ensure treatment was relevant and effective. (Benzodiazepines are medicines that help relieve nervousness, tension, and other symptoms by slowing the central nervous system.) Patients were supported by the practice in relation to their drug usage and were on a rehabilitation programme managed by other health organisations.

Management, monitoring and improving outcomes for people

Staff at 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 information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last two years. One example of a completed audit (this is where the practice was able to demonstrate the changes resulting since the initial audit) related to bone density and provision of bone protection medicines for at risk groups of patients. The initial audit identified patients who were at risk and required a scan to find out whether they had thinning bones and whether medicines could be prescribed to minimise the risk of fractures. A second audit showed that of the patients identified improvements had been made to their treatment and other patients were identified who also might be a risk.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a system in place for managing long term conditions, whereby patients were offered an annual review during their month of birth. The practice was performing well against all QOF indicators, apart from

Good

Are services effective?

(for example, treatment is effective)

diabetes care. The practice had undertaken further work to determine why this was the case and found that there were patients who chose not to attend their reviews; or chose not to comply with recommended treatment.

In response to areas of concern that the practice had identified, audits of referrals to hospitals had been carried out for all GPs, to ensure they were achieved in a timely manner and were relevant and appropriate. This work had commenced about six months prior to our inspection and was on going, the practice reported that there had been an improvement in referrals being made in a timely manner, which had previously caused distress to a few patients.

The practice facilitated monthly palliative care meetings and a GP would attend each meeting on a rotational basis. The practice maintained a whiteboard with relevant information of patients receiving palliative care to ensure all relevant staff were aware of the patients' current needs and wishes.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, in managing long term conditions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Role specific training was also available. The lead nurse for diabetes management said they received a yearly update on the condition and networked every two months with other diabetes specialist nurses. The nurse said that training was provided online or face to face. Support was also given by GPs in the practice and the nurse had reflection sessions with them to consolidate what they had learnt and share updates. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff received an appraisal in 2013 and the practice manager was in the process of organising the next round of appraisals to commence in January 2015. The practice manager explained that they had only been in post for less than six months and wanted to get to know the staff and their specific roles before assessing their performance. We noted that one member of staff had received an appraisal in March 2014 and saw that a learning development plan had been put into place to meet identified learning needs.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

The assistant practice manager was responsible for staffing issues and had responsibility for recruitment and welfare of staff.

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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. For example when information was received from out of hour's providers or minor injuries were scanned onto the system for the attention of the duty GP, as well as the usual GP for the patient, for action. GPs told us they would speak with paramedics when needed to try and manage patients in their own homes. They added that the practice links with the community respiratory team had decreased the number of home visits to patients with a respiratory disorder.

Health visitors met with the staff responsible for monitoring patients who did not keep their appointments, for example, childhood vaccinations and appropriate follow up action was agreed. Health visitors also met with the practice six weekly to discuss children at risk and the practice was

devising a system to highlight this on patient records without breaching confidentiality. The practice also had contact with district nurses who visited the practice most days and attended palliative care meetings.

The practice catchment area covered eight care homes and they worked with other GP practices to streamline the services offered.

Information sharing

The practice used electronic systems to communicate with other providers. For example, when a patient experiencing mental health problems presented at the practice their previous GP was faxed with a request for a summary of their medical notes. Information from palliative care meetings was provided to the out of hour's provider to ensure they had up to date information on a patient's wishes and current treatment for their end of life care.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Consent to care and treatment

The practice manager had informally checked that all staff were aware of the MCA 2005 and how it was used in practice. We found that the majority staff were aware of the Mental Capacity Act 2005 their duties in fulfilling it and how to implement it in practice.

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. One of the lead nurses responsible for carrying out health checks for patients with learning disabilities explained the importance of building a rapport with the patients and explaining treatment in a meaningful way.

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 nurses and GPs demonstrated a clear understanding of Gillick competencies. (Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.)

Health promotion and prevention

The practice had a range of health promotion leaflets in their waiting area and the patient participation group notice board contained relevant information on support services. GPs said they opportunistically gave patients leaflets from websites when they had their appointments, these covered conditions such as diabetes and asthma. The practice website had an area which focused on health promotion and the NHS checks available at the practice, for example for over 75s. There was information on local drug and alcohol centres that patients were able to self-refer to if they chose to.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. Patients were greeted politely and staff assisted them with their request, for example, arranging a repeat prescription. Telephone calls were taken away from the main reception desk and low level music was also playing to aid privacy.

They practice ensured that the Out of Hours service was aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

All the patients we spoke with and the comment card completed were complimentary of the staff at the practice and the service received.

Patients told us that they felt listened to and involved in the decisions about the care and treatment. Patients expressed their views and were involved in making decisions about their care and treatment. Patients were given appropriate information and support regarding their care or treatment. Patients told us that the doctors took time to explain things to them. Patients said they had the opportunity to ask additional questions if they needed to and felt their concerns were listened to.

The practice identified all vulnerable groups and offered personal care plans which were updated regularly and included medication use and wishes of patients at end of life.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

The practice maintained a list of carers and would place an alert on their records to inform other staff members of the patient's caring responsibilities or whether they were cared for. The practice was working with school nurses to identify children who were carers for other people, such as their parents.

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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population).

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This mainly concerns appointments times and availability. On the day of our inspection the PPG were carrying out a survey to monitor the effectiveness of the current appointment system to identify where improvements could be made. We spoke with a member of the PPG who said that they viewed this aspect of their role as being supportive of patients and the practice and facilitated communication.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients who were experiencing poor mental health were able to access a same day triage service. This information was made available through the practice's website and information displayed in the waiting area. Staff said that they would always add these patients onto the same day list and if needed would talk to other health professionals, such as community psychiatric nurses and obtain information form a patient's previous practice on their medical history if appropriate.

The practice had access to online and telephone translation services for patients whose first language was not English. The main areas of the practice website were able to be translated into other languages and the size of the print magnified if needed.

The practice was fully accessible to the disabled, and all the patient areas including the waiting room, consulting rooms and toilets had wheelchair access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was an automatic door at the entrance to the practice which opened automatically when patients arrived at the practice. There was a specific button to press upon exiting, which not all patients were aware how to use, therefore reception staff would offer assistance,

Access to the service

The practice offered routine appointments between 8.30am and 6pm Monday to Friday. On Mondays pre bookable appoints were available from 6pm to 7.30pm and there were early morning appointments on Friday mornings from 7am to 8.30pm. Outside of these times patients were directed to the out of hour's provider.

The practice manager said that they were constantly reviewing appointments availability and worked with the patient participation group to gather the views of patients. Patients were able to book appointments on line, via telephone calls or face to face. The practice had used text messaging reminders, but this had not been successful, as there was no indication on the message who and what the appointment referred to. The practice planned to roll out and improve text message reminder which would include the name of the practice. We noted that although appointments were made available for booking up to two weeks in advance, there were none available for the two weeks following our inspection. Staff said that they would always see patients with urgent conditions through their triage system, which patients confirmed.

Telephone triage appointments were available all day, apart from during the extended hours periods and were dealt with by either a GP or a nurse, dependant who the most appropriate member of staff to manage the condition. Childhood immunisation clinics were held every Thursday from 9.30 to 11am and an appointment was not necessary.

Double appointments were offered for vulnerable patients who had been identified on the practice system and these could be requested if needed. Staff said that housebound patients were offered flu vaccinations in their own homes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

The complaints policy covered how concerns would be handled, for example, if a patient made a verbal complaint, notes were taken and the patient would be asked if they required a response to their concerns in writing. If complaints were received via email, then the practice manager would respond and maintain a record. We looked at the complaints and concerns received over the past year.

The majority of them related to availability of appointments, none of the complaints were about care or treatment received once an appointment had been arranged. All concerns had a written response and we saw that in November 2013 there had been a higher number of complains due to unplanned GP absence, which had reduced the availability of appointments.

We noted themes of telephones not being answered promptly and complaints about delays in referrals. We saw that the practice had put measures into place to address these and were monitoring improvements made on an on going basis. Staff said they were made aware of concerns that affected their role, but were not routinely informed of all concerns that the practice received.

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, strategy and set of values, which primarily focused on quality of patient care and experience. We saw staff demonstrated a positive attitude change and the challenges facing GPs practices. The managers were able to tell us about how they had reorganised meetings with staff and were further developing these to ensure all staff were informed of the business plans for the practice.

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 a sample these policies and procedures, such as safeguarding, fire safety and complaint handling. We noted that some had been devised in May 2006, but there had been no review or update to show that the information had been looked at to ensure it was current.

The practice had a range of meetings in place which included partners practice meetings on a fortnightly basis, senior management meetings on a fortnightly basis and whole practice meetings twice yearly. Information discussed in these meetings included Quality and Outcomes framework compliance, significant events and complaints. We saw that meeting minutes were comprehensive with an action log completed to show what changes had been made and progress on improvements made.

Other meetings which covered safe practice included a medicines management meeting twice a year and monthly community liaison meetings where patients care and treatment was discussed with relevant health professionals, such as health visitors and district nurses.

One of the practice nurses had links with the clinical commissioning group (CCG) and a practice nurse forum in the area to discuss latest guidance and treatments. The practice manager met with other practice managers in the local CCG to discuss forthcoming changes to practice populations such as an increase in numbers, due to housing development and ways of working across the CCG area to streamline the service provided for patients, such as carrying out joint clinics.

The practice had a named Caldicott guardian who was responsible for sharing and storing information. All staff received training on information governance during their induction. Staff we spoke with were aware of the need to ensure confidential information about patients. was stored securely. For example, the practice computer system was password protected and staff were only able to access relevant areas.

The practice had a safety management folder related to environmental risks at the premises, such as safe handling of chemicals and fire safety; however, written risk assessments had not been developed to show how risk if present would be minimised.

The practice manager said that training needs for all staff were discussed in senior management and partners meetings, but was not formally reported to identify how these would be planned for.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were able to raise issues at team meetings. We also noted that social events were held twice yearly. One receptionist commented that GPs were approachable and all members of the duty team had mobile telephones, which reception staff were able to contact them on if needed at any time.

Nurses who were responsible for telephone triage appointments said they were able to speak with GPs for advice if needed during these appointments. They considered staff worked well as a whole team and within their sub teams, for example, the nursing team.

Practice seeks and acts on feedback from its patients, the public and staff

A range of meetings were available for staff to comment on service provision, such as reception staff meetings and practice meetings. We noted that information from senior managers meetings was disseminated to staff. There was also a secure staff suggestion box in the staff room which enabled staff to comment privately if they chose to do so. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Patients we spoke with and the comment card a patient had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG).The PPG had carried out surveys and met every six weeks. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. GPs from the practice also attended training sessions provided by the local clinical commissioning group on a quarterly basis and used these opportunities to share best practice. The practice had completed reviews of significant events and other incidents and shared with staff at their meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must operate effective recruitment procedures and ensure that information specified in Schedule 3 is available in respect of people employed for the purposes of carrying on a regulated activity.** 21 (a) (b)