Mayfield Medical Centre

Quality Report

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

Ratings

Overall rating for this service	**Good**
Are services safe?	**Good**
Are services effective?	**Requires improvement**
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 Mayfield Medical Centre on 30 June 2015. The practice was rated as good for all domains with the exception of effective services which was rated as requires improvement. All population groups were rated as good.

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

- The practice had a strong system in place to capture, investigate and learn from significant events. The lead GP oversaw this process and meetings were held monthly to discuss each event and learning taken from the outcome. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice did not have an effective system to record staff training and some basic training had not been completed. However, staff had regular appraisals and personal development plans.
- The practice had achieved a score of 98.5% of the percentage points available to them for Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. QOF is a voluntary incentive scheme for GP practices in the UK for providing recommended treatments for the most commonly found clinical conditions.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Data showed that patients rated the practice higher than others for several aspects of care. We saw that staff were considerate with patients, treated them with understanding and maintained confidentiality.
- Information about services and how to complain was available and easy to understand.

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- The practice had recognised they needed to improve the way patients made appointments and had recently changed the appointment system which was a clinician led triage system. This was to be reviewed six months after implementation.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

However, there was an area of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure staff receive appropriate training in order to carry out the duties they perform and maintain accurate records of this.

The provider should:

- Introduce an infection control audit.
- Carry out a health and safety risk assessment and regular fire drills.
- Carry out a risk assessment as to why some non-clinical staff had not received a disclosure and barring check (DBS).

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?

Good

The practice is rated as good for providing safe services.

The practice had a comprehensive system in place for reporting, recording and monitoring significant events. The lead GP oversaw this process and meetings were held monthly to discuss each event and learning taken from the outcome. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used opportunities to learn from incidents to support improvement and provide feedback to other organisations involved in incidents. The practice had regular multidisciplinary meetings to discuss the safeguarding of vulnerable patients.

Some risks to patients who used the services were assessed, however the systems and processes were not fully embedded to ensure patients and staff were kept safe. For example, there was no infection control audit which would reduce the risk of health care related infections.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

The practice did not have an effective system to record staff training and some basic training had not been completed. Staff received regular appraisals and had personal development plans.

Data showed patient outcomes were above national averages except for diabetes. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 98.5% of the points available. This was above the national average 94.2%. The practice were aware of and had appointed a new clinical lead and an action plan had been implemented to make improvements.

Patients' needs were assessed and care was planned and delivered in line with current legislation. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

Data showed that patients rated the practice above the national averages for being caring. The National GP Patient Survey from January 2015 showed the majority of patients were happy with the care received. For example, the proportion of patients who described their overall experience of the GP surgery as good or very good was 94%, which was above the clinical commissioning group (CCG) average of 89%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 89%, the CCG average was 89%. The proportion of patients who said the nurse was good or very good at treating them with care and concern was 96%, the CCG average was 90%. Patients told us that patients were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.

Some patients raised concerns about privacy at the main reception desk, however funding had been secured and improvements to assist privacy at the reception desk were due to be made. We received positive feedback from patients regarding the support the practice provided to patients who required palliative care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

They reviewed the needs of their local population to secure improvements to services where these were identified. Results of the National GP Patient Survey from January 2015 showed that 57% of patients found it easy to get through to this surgery by phone the local CCG average was 82%, 91% were able to get an appointment to see or speak to someone the last time they tried local CCG average was 86% and 97% say the last appointment they got was convenient local CCG average was 93%. The practice had recognised they needed to improve the way patients made appointments and had recently changed the appointment system which was a clinician led triage system. This was to be reviewed six months after implementation.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded to issues raised.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. There was a documented mission statement. Staff understood their responsibilities in relation to the practice aims and

Summary of findings

objectives. There was a well-defined leadership structure in place with designated staff in lead roles. Staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify some risk. However, the practice did not have an infection control audit or health and safety risk assessment and were not carrying out regular fire evacuations.

The practice sought feedback from staff and patients, which they acted on. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

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.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 2 percentage points above the local Clinical Commissioning Group (CCG) average and 2.9 points above the England average.

The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people. High risk groups of elderly patients, such as those receiving palliative and residential care had care plans in place. One of the GPs had responsibility for visiting a local nursing home every two weeks. They would contact the care home in advance of their visit to prepare to visit the patients who needed to be visited or reviewed. There was a dedicated repeat prescription telephone line for house bound patients.

People with long term conditions

Good

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

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients with long-term conditions such as hypertension and diabetes, structured annual review to check that their health and medication needs were being met, or more often where this was judged necessary by the GPs.

Longer appointments and home visits were available when needed. Recall appointments were aligned to the patients birthday month and a holistic review of the patient's long-term conditions would be carried out in one appointment where possible by the practice nurse. This group of patients were offered immunisations for pneumonia.

Families, children and young people

Good

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

Summary of findings

The practice had identified the needs of families, children and young people, and put plans in place to meet them. The practice had a dedicated GP and a practice nurse appointed as the lead for safeguarding vulnerable children. There was a safeguarding children policy. There were regular multidisciplinary team meetings involving child care professionals such as health visitors. This covered safeguarding and families who required support.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Some of the data for the last year's performance for immunisations was slightly below the averages for the clinical commissioning Group (CCG) for children aged under 12 months and 24 months. However, at the age of five the percentages of children receiving vaccines was in line with the CCG averages. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. There was a same day telephone access to a clinician service and if an appointment was necessary it could be arranged at a suitable time for the patient. The practice operated a text reminder service for patients who had registered their mobile phones with the practice. There were extended opening hours until 7:30pm on Thursday which was useful for patients with work commitments.

The practice offered repeat prescriptions on line. They offered a full range of health promotion and screening which reflected the needs for this age group for example smoking cessation clinics.

People whose circumstances may make them vulnerable

Good

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

The practice had effective working relationships with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

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The practice carried out annual health reviews of patents with learning disabilities, there was a spread sheet used as the recall system for this. Patients could access drug and alcohol support services via the practice and an in-house drug and alcohol counsellor attended the practice weekly. Vulnerable patients had the ability to pre book or book appointments on the day without having a triage appointment.

The practice's computer system alerted GPs if a patient was also a carer. There was support available for carers from the local carer's support group. Carer's were given the dedicated telephone line number to use for repeat prescriptions.

People experiencing poor mental health (including people with dementia)

Good

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

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. All patients aged over 75 had been notified of their named GP. 83.3% of patients experiencing dementia had received annual reviews, the England average is 77.9%. There was a template for the GPs to complete if patients were identified as being at risk of dementia. The patients would have bloods screened and attend a 20 minute appointment for an assessment.

Both of the GP partners had diplomas in mental health conditions. Annual review appointments were offered for this group of patients with a GP of their choice. There was access to a GP for patients experiencing poor mental health on the day regardless of urgency. The practice had developed its own template in order to carry out comprehensive reviews.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 98.4% of the points available to them for providing recommended care and treatment for patients with poor mental health. This was 8.6 percentage points above the local CCG average and 8 points above the England average.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection; this included two members of the patient participation group (PPG). All of the patients were satisfied with the care they received from the practice. They told us staff were friendly and helpful and they felt supported and listened too in their appointments. Some patients raised concerns about privacy at the main reception desk. The practice had recently changed the way patients could make appointments, they had introduced a telephone triage system. Patients response to this was mixed. Some found it difficult to use and others thought it had improved access.

We reviewed one CQC comment card completed by a patient prior to the inspection. This gave us positive feedback about the practice.

The latest GP Patient Survey published in January 2015 showed the majority of patients were satisfied with the services the practice offered. Most patients who responded described their overall experience as good. (94% compared to the local clinical commissioning group (CCG) average of 89%)

The three responses to questions where the practice performed the best when compared to other local practices were:

- 88% of respondents would recommend this surgery to someone new to the area Local CCG average: 82%.
- 97% of respondents say the last GP they saw or spoke to was good at giving them enough time Local CCG average: 92%.
- 94% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern Local CCG average: 91%.

The three responses to questions where the practice performed least well when compared to other local practices were:

- 60% of respondents find it easy to get through to this surgery by phone Local CCG average: 82%.
- 41% of respondents with a preferred GP usually get to see or speak to that GP Local CCG average: 61%.
- 68% of respondents usually wait 15 minutes or less after their appointment time to be seen Local CCG average: 75%.

These results were based on 120 surveys that were returned from a total of 314 sent out; a response rate of 38%.

The practice carried out its own survey at the beginning of 2015, 150 surveys were completed, the feedback was;

- The majority of patients scored the practice clinicians as “very good” for honesty, trust and confidence.
- The majority of patents found reception staff very helpful.
- Patients were satisfied with opening times with a significant percentage of 60% happy to see any GP.
- The behavioural skill-sets of the clinicians were highly rated by patients with almost all of the respondents scoring GPs and nurses in the highest category possible.
- Our patients gave us an almost unanimous endorsement that they would be happy to see the same clinician again.

From the survey the practice identified areas where they could improve which were patients finding difficulty with telephone access, patients found making an appointment onerous and the number of appointments did not meet the needs of the practice population.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure staff receive appropriate training in order to carry out the duties they perform and maintain accurate records of this.

Action the service SHOULD take to improve

- Introduce an infection control audit.
- Carry out a health and safety risk assessment and regular fire drills.
- Carry out a risk assessment as to why some non-clinical staff had not received a disclosure and barring check (DBS).

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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 a specialist advisor with experience of GP practice management and a member of CQC administration staff.

Background to Mayfield Medical Centre

The area covered by Mayfield Medical Centre is predominantly Jarrow also parts of Hebburn and Boldon Colliery. The practice provides services from the following address and this is where we carried out the inspection, Park Road, Jarrow, Tyne and Wear, NE32 5SE.

The surgery is purpose built and has been extended. The facilities are on the ground floor with disabled access and a car park.

The practice has two GPs partners, three salaried GPs and GP registrars (a fully qualified doctor allocated to the practice as part of a three-year, general postgraduate medical training programme), two of the GPs are female and three male. The practice is a training practice. There are two nurse practitioners and two practice nurses (one post is vacant, which is due to be taken up in August 2015) and two health care assistants. There is a business manager, operations manager and an office manager. There are 13 administrative staff which include secretaries, receptionists and administration clerks.

The practice provides services to approximately 9,200 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) agreement with NHS England.

The practice was open Monday to Friday 8:30am to 6:00pm and until 7:30pm on Thursdays. Patients were able to book appointments either on the telephone, at the front desk or using the on-line system.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

We inspected this service as part of our 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 registered 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.

How we carried out this inspection

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?

Detailed findings

- 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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

We carried out an announced visit on 30 June 2015. During our visit we spoke with a range of staff. This included GPs, practice nurses and reception and administrative staff. We also spoke with seven patients. We reviewed one CQC comment card where a patient and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

As part of our planning we looked at a range of information available about the practice from the National GP patient survey and the Quality Outcomes Framework (QOF), which is a national performance measurement tool. The latest information available to us at the time of the inspection indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. For example, a patient was only meant to be seen by a male clinician. An appointment was made in error with a female clinician. The business manager arranged for further staff training to be carried out in relation to alerts on patient records.

Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records, incident reports and minutes of meetings. These showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a comprehensive system in place for reporting, recording and monitoring significant events. They were open and transparent when there were near misses or when things went wrong. There were records of significant events and we were able to review these. The GP and business manager told us that significant events were managed by the lead GP. Complaints were sometimes recorded and investigated as significant events, if appropriate. There was a monthly meeting held where significant events were discussed.

We saw comprehensive minutes of the meetings, where discussions took place with clear learning points taken away. There were several examples of significant events where feedback was supplied to other agencies. For example, there was an incident with a patient who had multiple mental health issues. The practice carried out an investigation to see if there was more they could have done regarding the incident. They concluded that there were no learning points, however the local crisis team were contacted regarding their contact with the patient and the practice are awaiting a response. Every year in March the practice held a review of significant events, complaints for any patterns or trends.

National patient safety alerts came to the practice via a generic email. The business manager had responsibility to disseminate the alerts to the most appropriate member of staff. The operations manager would then ensure the appropriate staff read them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They met with health visitors on a monthly basis to discuss safeguarding issues. The practice had a dedicated GP and a practice nurse appointed as the lead for both safeguarding vulnerable adults and children. There was a safeguarding children and vulnerable adult's policy. Staff we spoke with were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

Staff told us they had been trained to the appropriate level for child safeguarding. The lead GP for safeguarding told us they had been trained to level 3. We saw documented evidence that some staff had attended safeguarding adults training in 2013.

The business manager told us new members of staff went on safeguarding training within six weeks of starting their role. We were unable to see evidence of training certificates for staff in relation to safeguarding. The business manager told us that the local safeguarding team at the local authority had provided training and they did not provide the practice with individual training certificates.

The practice had a chaperone policy which had been reviewed in December 2014. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone. Staff we spoke with told us that the clinical staff, which included the health care assistants acted as chaperone if required, they had received training for this role.

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Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. 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. Blank prescription forms were handled according to national guidelines and were kept securely.

We saw that only one thermometer was working in the vaccines refrigerator. Public Health England, protocol for ordering, storing and handling vaccines states that all refrigerators should ideally have two thermometers, one of which is a maximum/minimum thermometer independent of mains power.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

We saw the practice was clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities.

The member of staff nominated as the infection control lead had been absent from work, a practice nurse was due to take up this role in the next few weeks. There was an infection control policy which included guidance, for example, hand washing.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

We asked about infection control training for staff and were told by the business manager that the new infection control lead was to go on specific training for this role when they were to take up their post. The training matrix showed staff had received infection control training, however we were unable to confirm what this was and by whom it was delivered.

We asked to see infection control audits. We were told these had not been carried out, the practice was waiting for the new infection control lead to take up their post. The business manager had carried out an infection control risk assessment, which we saw. It identified issues such as untidy consulting rooms and foot pedals not working on clinical waste bins, which they told us had been addressed. There was no action plan or timescale attached to the risk assessment to address these issues. There was no schedule to indicate how often the privacy curtains were cleaned in the consulting rooms.

The consulting rooms had domestic taps on the sinks, they were not lever or sensor operated which would minimise the risk of contamination. The business manager told the taps were to be replaced in the next year.

The practice had a contract with a local cleaning company for the cleaning of the surgery. There were cleaning schedules in place for use by the contracted cleaning company for daily, weekly and monthly tasks. The business manager made regular checks to ensure these were being followed.

We were provided with a legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessment in the days following our inspection via email as it was not provided on the day.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments which was appropriate for patients' needs. The practice had a range of equipment which included medicine fridges, patient couches, sharps boxes (for the safe disposal of needles) and fire extinguishers. 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.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting clinical and

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Are services safe?

non-clinical staff. Staff recruitment records we looked contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

We discussed criminal records checks which are made via the Disclosure and Barring Service (DBS) with the business manager. All clinical staff had received a DBS check and non-clinical staff who had been employed after April 2013. However there was no documented risk assessment for non-clinical staff who had been employed prior to April 2013 as to why they had not received a DBS check. The practice manager said they knew the rationale as to why they had not carried these out but had not formally documented this and would carry this out as soon as possible.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. We saw there was a rota system in place for each staff group, including GPs, to ensure there were enough staff on duty. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

The practice manager said the practice used locum GPs when this was necessary, although it had been over a year since this had been necessary. The business manager told us the practice only used locums from agencies once they had seen the locum's vetting information.

There were induction packages for different job roles within the practice, for example, we saw copies of inductions for GPs and for administration staff.

The operations manager carried out checks to ensure that clinical staff had up to date registration with professional bodies such as the Nursing and Midwifery Council (NMC). There was also a log of medical indemnity insurance for clinical staff and the date it was due for renewal.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included a health and safety policy, medicines management, staffing, dealing with emergencies and equipment, however there was no infection control audit.

The business manager identified health and safety as being manual handling, control of substances, fire procedures and control of substances hazardous to health (COSHH). There was no risk assessment of health and safety hazards particular to the building, for example, hazards in that would, for example, result in slips and trips. The business manager had undertaken health and safety and fire training and showed us a certificate in relation to this. Staff had not undertaken health and safety training. Following the inspection the business manager sent us guides the practice used regarding visual display units (VDU) and manual handling. There were examples of signature sheets staff were required to sign when they had read and understood the guides.

The practice had a fire risk assessment. The business manager was the fire officer for the practice; some members of staff were fire marshals. There was no formally documented fire training for staff other than for the business manager. They told us they provided in-house fire training to staff. We confirmed that fire equipment was tested regularly. There had not been a recent fire evacuation drill as we were told there had been no time to do this.

The business manager explained that they had good arrangements with local firms who carried out any maintenance work needed to the building and they felt the arrangements they had for the cleaning of the building worked well.

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines were available in a secure area of the practice and all staff knew of their location. The defibrillator and oxygen were accessible and records of weekly checks were up to date.

On the day of the inspection we could not to confirm in staff training records that staff were trained in basic life support. The business manager said she would send us this information after the inspection. We were then sent a sheet with the names of all staff at the practice and the date they had received this training. Four members of administration staff had not received basic life support training but were booked to receive this in August 2015.

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Are services safe?

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 were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plans were held by the practice manager and GPs at their homes and contact details were available if the buildings were not accessible.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies. The practice were currently updating the practice guidelines on diabetes.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the practice's performance and patients were discussed at clinical education meetings.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Recall appointments were aligned to the patients birthday month and a holistic review of the patient's long-term conditions would be carried out in one appointment where possible by the practice nurse. The GP would review if any changes or decisions needed to be made. The GPs were currently reviewing the patients with chronic obstructive pulmonary disease (COPD) due to practice nurse staffing issues.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. 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. We saw the practice had achieved a score of 98.5% of the percentage points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local clinical commissioning group (CCG) by 3.2 percentage points and England averages by 5 percentage points.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for clinical audit. We saw that clinical staff were actively involved in audit and re-audit cycles. Three, two cycle audits had been carried out in the last 12 months. We were provided with a list of at least 10 other audits which had been carried out in the last year. We saw an audit cycle which had been carried out which found 35% of prescribed antibiotics were not in line with local antibiotic guidelines. A second audit found 20% of those prescribed were justified and this cut the amount prescribed to 15% which were not in line with local guidance.

The practice used the information collected for the QOF and performance in national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with hypertension for known risk factors. The practice met all the minimum standards for QOF, the only exception being diabetes where they were below the local clinical commissioning group (CCG) by 1.1 percentage points but above the England average by 2.4 percentage points. The practice were aware that they were below previous years indicators for diabetes and had appointed a new clinical lead and an action plan had been implemented to improve.

The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement, there were clinical education meetings held every 5 weeks where audits which had been carried out were presented and discussed.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice 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.

Effective staffing

The practice did not have an effective system to record staff training and some basic training had not been completed. The practice sent to us a training matrix prior to our inspection which we requested. This did not include some basic training such as fire training and information governance, it did not indicate when staff required refresher training. Entries on the matrix next to some training such as basic life support, health and safety and safeguarding were blank. We asked to see a sample of staff members training files to confirm training. We were given a plastic wallet with copies of certificates for each member of staff. There was little evidence that staff had received basic training of safeguarding and basic life support. However, there was evidence, for example, in the case of a healthcare assistant of training specific for their role such as chaperone training, asthma and flu updates, spirometry training, basic life support, safeguarding children, smoking cessation and ear irrigation training.

All GPs were up to date with their yearly continuing professional development requirements and all had either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list).

The operations manager explained the process for staff appraisal. One of the lead GPs was the lead for clinical supervision of the practice nurses and healthcare assistants. We looked at a sample of four staff appraisals which were comprehensive. Staff told us they found this a useful process. Staff also had personal development plans. We saw that some staff had requested additional training specific to their role such as batch prescribing and updates on the choose and book process for hospital appointments.

Working with colleagues and other services

The practice could demonstrate that they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held multidisciplinary team meetings every week, with the subject in four week rotation. There were meetings which covered safeguarding, clinical issues and palliative care. These meetings were attended by the practice's GPs and nurses along with district nurses, social workers, community psychiatric nurses, drug and alcohol workers and palliative care nurses depending upon the meeting.

The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area, which were discussed in clinical meetings. This helped to share important information about patients including those who were most vulnerable.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the NHS 111 service, were received both electronically and by post.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

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

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent.

Requires improvement

Are services effective?

(for example, treatment is effective)

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA) on a patient by patient basis. We found the GPs were aware of the MCA and used it appropriately and told us they had received MCA training. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

New patients were required to complete a registration form and questionnaire and then make an appointment with the health care assistant for a new patient health check.

Information on a range of topics and health promotion literature was available to patients in the waiting areas of the practice. There was information on the practice website regarding family health, for example, nose bleeds and chickenpox. Information was also available regarding health clinics for long term conditions. The practice offered a range of health clinics which included minor surgery and cervical screening.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data showed the practice had obtained 100% of the points available to them for providing support with blood pressure. This was 2.7 percentage points above the local CCG average and 5.1 points above the England average. The data also showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages.

The QOF data showed the practice obtained 98.3% of the points available to them for providing cervical screening to women. This was 0.8 percentage points above the local CCG and England averages. The practice had procedures in place for the management of cervical screening. The proportion of patients eligible for screening who had been tested was 75.4%; this was slightly lower than the national average (76.9%).

The practice offered child health and anti-natal clinics. A full range of immunisations for children, in line with current national guidance were offered. Some of the data for the last year's performance for immunisations was slightly below the averages for the CCG for children aged under 12 months and 24 months. However, at the age of five the percentages of children receiving vaccines was in line with the CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey (January 2015). For example, the proportion of patients who described their overall experience of the GP surgery as good or very good was 94%, which was above the clinical commissioning group (CCG) average of 89%.

The proportion of patients who said their GP was good or very good at treating them with care and concern was 89%, the CCG average was 89%. The proportion of patients who said the nurse was good or very good at treating them with care and concern was 96%, the CCG average was 90%. The practice carried out its own survey at the beginning of 2015, 150 surveys were completed, the majority of patients scored the practice clinicians as "very good" for honesty, trust and confidence.

We spoke with seven patients on the day of our inspection; this included two members of the patient participation group (PPG). All of the patients were satisfied with the care they received from the practice. They told us staff were friendly and helpful and they felt supported and listened too in their appointments. Some patients raised concerns about privacy at the main reception desk. The lead GP and business manager told us they were well aware of this issue. They had recently made a successful bid for central government funding to improve the practice and very soon were going to start improvements to the reception area to assist privacy. A confidential room was to be built where staff could speak with patients.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. The GP national survey data showed 91% of patients found the receptionists helpful; the CCG average was 83%. The practice's own survey showed that the majority of patents found reception staff very helpful.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

Care planning and involvement in decisions about care and treatment

Patients told us they felt listened to by the GPs and practice nurses. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

From the 2015 National GP Patient Survey, 87% of patients said the GP they visited had been good at involving them in decisions about their care (CCG average was 86%). The data showed that 90% of patients said the practice nurse they visited had been good at involving them in decisions about their care (CCG average 87%).

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice's computer system alerted GPs if a patient was also a carer. There was support available for carers from the local carer's support group. Carer's were given the dedicated telephone line number to use for repeat prescriptions.

There was a palliative care register and regular contact with the district nurses. There were monthly palliative care meetings which involved GPs, district nurses and palliative care nurses. The practice had close links with the local hospice. They told us about support they had given to a patient who wanted to receive end of life care at home. They had supported the patient and received positive feedback from the family on the care their relative received. Staff told us that they had provided bereavement support where it was needed. Patients we spoke with commented positively at how good the practice were with supporting patients who required palliative care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. Patients we spoke with said they felt the practice was meeting their needs. Where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the patient's medical record. This meant the GP would already be aware of this and any additional support could be provided, for example, a longer appointment time.

All patients aged over 75 had been notified of their named GP. High risk groups of elderly patients, such as those receiving palliative and residential care had care plans in place. 83.3% of patients experiencing dementia had received annual reviews, the England average is 77.9%. There was a template for the GPs to complete if patients were identified as being at risk of dementia. The patients would have blood screened and attend a 20 minute appointment for an assessment.

The practice had a palliative care register which was discussed at multi-disciplinary meetings every four weeks. One of the GPs had responsibility for visiting a local nursing home every two weeks. They would contact the care home in advance of their visit to prepare notes of the patients who needed to be visited or reviewed.

Both of the GP partners had diplomas in mental health conditions. Annual review appointments were offered for this group of patients with a GP of their choice. Patients with poor mental health would always be given a same day appointment with a GP. The practice had developed its own template in order to carry out comprehensive reviews.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the practice patient participation group (PPG). The group was in its infancy and had held three meetings; there were two members with four more interested in joining. The group had influenced changes to the marking of the disabled bays in the car park and encouraged the practice to give staff name badges. We spoke with the two members of the group who told us they were planning to suggest a newsletter for the practice and a virtual PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended on a Thursday evening to provide pre-bookable appointments with a GP. This information was displayed on the practice's website to keep patients informed. This helped to improve access for those patients who had work commitments. The practice had access to translation services, including sign language, if required. One of the salaried GPs spoke Urdu.

The practice carried out annual health reviews of patents with learning disabilities, there was a spread sheet used as the recall system for this. Patients could access drug and alcohol support services via the practice and an in-house drug and alcohol counsellor attended the practice weekly.

All of the treatment and consulting rooms and toilets could be accessed by those with mobility difficulties. There were designated disabled parking spaces in the surgery car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP.

Access to the service

The practice was open Monday to Friday 8:30am to 6:00pm with the exception of extended hours until 7:30pm on Thursdays. Patients were able to book appointments either on the telephone, at the front desk or using the on-line system.

The National GP Patient Survey 2015 showed patient satisfaction regarding access was above and below the local CCG average.

- 57% found it easy to get through to this surgery by phone - local CCG average: 82%
- 42% with a preferred GP usually get to see or speak to that GP – local CCG average: 65%
- 91% were able to get an appointment to see or speak to someone the last time they tried - local CCG average: 86%
- 97% say the last appointment they got was convenient - local CCG average: 93%

The practice had concluded from their own survey at the beginning of 2015 that areas they could improve upon was patients telephone access, patients found making an appointment onerous and they did not have enough pre

Good

Are services responsive to people's needs?

(for example, to feedback?)

bookable appointments available. Therefore, from 1 June 2015 the practice changed the way patients could make appointments. They introduced a telephone triage system. This was to be reviewed after a pilot of six months. Response from the patients we spoke with regarding the new system was mixed. Some found it difficult and others thought it had improved access.

To book an appointment patients would be asked by the receptionist to explain briefly what the problem was then a telephone triage with a clinician would be arranged. The appointment would be made with the most suitable person and where possible the GP of the person's choice and on the same day.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. There were three urgent, on the day, appointments available with the on call GP. Routine appointments were generally not available for patients to book ahead unless the GP directed, for example, for test results, most patients were seen on the same day. Any patients with specific needs, for example, cognitive impairments could book appointments in advance. We checked the call logging system on the day of the inspection and the average response time to calls was one and a half minutes.

Information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. 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. Repeat prescriptions could also be ordered on-line or at reception. There was a dedicated repeat prescription telephone line for housebound and elderly patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints information leaflet for patients did not specifically contain information regarding taking a complaint further than the practice, for example to NHS England or the parliamentary Ombudsman. Following the inspection the business manager emailed us the complaint leaflet for patients which had been updated with this information. The business manager was the designated responsible person who handled all complaints in the practice. The lead GP also saw all complaints routinely and actively invited patients to attend the practice to discuss their concerns.

The practice manager supplied us with a schedule of eighteen complaints which had been received in the last 12 months. We looked at a sample of responses to the complaints and found these had all been dealt with in a satisfactory manner. Some complaints where necessary were raised as a significant event which were discussed at a specific meeting every month. Complaints and significant events were reviewed annually every March for patterns and trends.

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 vision 'to provide high quality primary care treatment to the patient population through consultation, examination and treatment of medical conditions. To seek to promote a healthy lifestyle to prevent disease and to aim to understand and meet the needs of the patient population and involve them in the decision making about their treatment and care'.

The practice were aware of what they did well, for example, their QOF achievements. Where they needed to make improvements they had identified the issues and developed an action plan, for example, diabetes care and improvements to the appointments system. The local walk in centre was due to close, the practice were planning for this as it will have an impact on the service provided locally, this involves the dispersal of a patient list which will see an increase in patients for the practice.

The practice recognised that there were many changes and challenges to general practice. This included recruitment. They were looking at alternative solutions to GP recruitment and had put themselves forward to participate in a new careers start scheme for GPs. One of the GP partners was involved in a meeting with NHS England where ideas were being put forward to provide better integrated care in the community. The idea being to develop a model with social care and clinical staff to be joined together.

The practice had a business development plan which covered the period 2014 – 2017. It set out the goals and objectives which the practice wished to achieve in the three year period. This included work on patient services, premises, staffing, patient participation and commissioning. The document was reviewed by the management team every six months.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date. There was a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies.

There were arrangements in place for identifying, recording and managing some risks such as equipment. However, the practice did not have an infection control audit or health and safety risk assessment and were not carrying out regular fire evacuation drills.

The practice had a strong system in place to capture, investigate and learn from significant events.

The practice used QOF data to manage performance; they were performing above the averages of the local CCG and across England as a whole. This was reviewed regularly. The practice had identified clinical leads for many of the QOF areas, for example asthma and dementia. The practice had carried out a number of completed clinical audit cycles, which it used to monitor quality and systems to identify where action should be taken.

The practice held regular meetings for staff. These included clinical business meetings, significant events, reception and administration meetings. Once a year an annual meeting of all staff would be held. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a well-established management team and a documented organisational chart. There were clear allocation of responsibilities. For example, one of the GP partners was the QOF lead. The business manager was responsible for the application of the practice's human resource policies and procedures. We spoke with staff and they 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. There were good levels of staff engagement and there was team working across all of the staff, both clinical and non-clinical.

We saw that there was strong leadership within the practice and the GPs were visible and accessible. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

We found the practice learned from incidents and near misses. Significant events meetings were held where such issues were discussed. Lessons learned from these discussions were shared with the relevant team members.

Are services well-led?

Good

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

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

The practice had made arrangements to seek and act on feedback from patients and staff. The GP partners and business manager told us they had been proactive in seeking feedback. Patient surveys were sent out to patients each year, in addition to the National GP survey.

There was a suggestion box in the waiting room and although in its infancy there was a patient participation group (PPG) open to all patients, who had begun to influence some changes in the practice.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had introduced the FFT, there were questionnaires available in the waiting room and instructions for patients on how to give feedback.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy and how to access it.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Although we found it difficult to verify some basic staff training we saw that clinical staff had received the clinical training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place.

The practice management team discussed any significant incidents that had occurred at a specific monthly meeting for this purpose. Reviews of significant events and other incidents had been completed and shared with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

Information and learning was also shared verbally between staff. The practice's schedule of meetings was used to facilitate the flow of information, including meetings of administrative staff, clinical staff and whole staff team meetings. Learning needs were identified through the appraisal process and staff were supported with their development.

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 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate training and training which had been carried out could not be evidenced.** **Regulation 18 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing (2) (a)**