Waltham Road Medical Centre

Quality Report

The Medical Centre,
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Website: none

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Waltham Road Medical Centre on 11 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia)

It required improvement for providing safe services and for services for people with long-term conditions.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. However patients with some long-term conditions were not being reviewed as often as best practice suggested. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider needs to make improvements.

Summary of findings

Importantly the provider must:

- Ensure that all staff have a common understanding of how to identify and report a significant event.

In addition the provider should:

- Review how patients with long-term conditions are managed to ensure that more patients receive the health reviews and tests that the guidance for management of their condition indicates.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However there was no common understanding of what constituted a significant event so there was no consistency in reporting them. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified as well as appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to comprehend. The process for referring patients to secondary care was tailored to each individual as well as being efficient. Staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and made improvements to services where these were identified as being required. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular practice meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings.

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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and priority appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. These patients had a named GP, however some of these patients were not receiving structured annual reviews to check that their health and care needs were being met.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were exceptionally high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

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, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group.

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 held a

Summary of findings

register of patients living in vulnerable circumstances such as homeless people, travellers and those with a learning disability. It had applied to carry out an enhanced service for patients with a learning disability but this had been declined because there were not enough patients within the practice with a learning disability.

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). All of the patients who experienced poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and 80% of patients diagnosed with dementia had had a face to face review of care during the preceding 12 months.

Summary of findings

What people who use the service say

We spoke with four patients. We received 27 completed comment cards.

All the patients we spoke with were pleased with the quality of the care they had received. The themes running through the comments cards and the patient interviews were that the staff were very kind and considerate. Several patients commented on how referrals were made quickly and with patients' involvement

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 299 survey forms were sent out to patients registered at this practice and 108 were returned. The main results from this were:

- Patients found it easy to get through to the surgery by telephone
- Patients reported that the experience of making an appointment was good
- Patients said that their overall experience of the practice was good
- The percentage of patients who would recommend the practice was below the national average.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff have a common understanding of how to identify and report a significant event

Action the service SHOULD take to improve

- Review how patients with long-term conditions are managed to ensure that more patients receive the health reviews and tests that the guidance for management of their condition indicates

Waltham Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist advisor and a practice manager specialist advisor

Background to Waltham Road Medical Centre

The Waltham Road Medical Centre is a GP practice located in an urban area of Gillingham, Kent and provides care for approximately 1,600 patients. The practice has more than twice the national average of patients over 75 and over 85 years of age. The number of people in the area who claim disability allowance is significantly higher than the national average.

There are two GP partners, one male and one female. There are 11 GP sessions each week, one session being half a day. There is a female practice nurses who provides five sessions each week. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a training practice.

Services are delivered from the central surgery at

The Medical Centre,

4a, Waltham Rd,

Gillingham, Kent,

ME8 6XQ.

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out- of- hours care.

Why we carried out this inspection

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

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

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

Detailed findings

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 11 December 2014. During our visit we spoke with a range of staff including a GP partner, nursing staff, receptionists and administrators. We spoke with patients who used 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example they considered reported incidents and accidents, national patient safety alerts as well as comments and complaints received. This was a small practice and staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff. The staff were aware of their responsibilities to raise concerns and knew how to report incidents or near misses. However there was no policy to guide staff on what was a significant event so there was no common understanding of what constituted a significant event.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents, but it did not always operate well. There had been two reported significant event over the previous year. One event that had been reported was a failure of technology. It had been reported in a comprehensive and timely way. Records demonstrated the action taken by the practice following the incident. The other was an incident where the wrong patient had been booked for an appointment. This had been recorded and investigated. Both events had been discussed at staff meetings.

However, we found three occurrences that could have been classified as significant events. They were all medical emergencies. In each case the situation was dealt with efficiently and effectively but none were recorded as significant events.

There was a process for dealing with safety alerts. These were received by the practice manager and passed to the GPs and nurses when the alerts were relevant. Records showed that one recent alert which concerned medicines had been received at the practice. The patients who were affected were identified and the instructions in the alert followed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that all the GPs and administration staff had received relevant role specific training on safeguarding. Staff told us that the practice nurse had received safeguarding training but records were not available to confirm this. 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. There were flowcharts at various points throughout the building advising staff to whom they should report a safeguarding issue and of the processes they should follow. The practice had a dedicated GP for safeguarding vulnerable adults and children who had undertaken the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead for safeguarding was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments such as patients with dementia. Staff were also able to use this system to identify an child patients that were on the local safeguarding register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice nurse had been trained to be a chaperone. When the nurse was not available to act as a chaperone, the practice manager, who had also been trained, undertook the role. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure that medicines were kept at the required temperatures and which described the action to take in the event of a power failure. There had been a power failure which had affected the storage of the vaccines as well as medicines and records showed that staff had followed the guidance in the policy correctly.

There were processes 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.

Requires improvement

Are services safe?

The practice was signed up to the local prescribing incentive scheme and met with the prescribing advisor from the local clinical commissioning group every six months. Changes had been made to medicines the practice prescribed following advice from the prescribing advisor. For example, changes from brand named to generic medicines. Patterns of prescribing of antibiotic, hypnotic, pain relief and anti-psychotic medicines were within the norms expected for such a practice.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of directions were available for staff to follow and records showed that the nurse had received appropriate training to administer vaccines. The directions were maintained on the practice computer and we were told they had been read by staff but they had not been signed.

There was a comprehensive policy for repeat prescribing. The practice had a system for checking repeat prescriptions were issued with reference to the medicine review date for each patient. Repeat prescriptions were handed into the practice, there was a repeat prescriptions box in the waiting room or patients handed them to the reception staff. There was a system for recording when and to which pharmacy patients' prescriptions had been sent, so staff were always able to resolve patients' questions about their prescriptions. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

Cleanliness and infection control

The premises were generally clean and tidy. There were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean. However, there was no formal check of the cleaners' work. Some areas of the practice, such as some skirting boards in the communal areas were dirty. The practice itself was not clear how often clinical waste bins were emptied as they were emptied "when necessary". There was no hand sanitiser in the waiting room.

The practice had a lead for infection control who had undertaken 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. The infection control lead told us that staff were updated annually. However records were not available to confirm this. The practice had carried out assessments to help keep infection control process up to date and effective.

The practice had an infection control policy, which included procedures and protocols for staff to follow such as hand hygiene, clinical waste, and personal protective equipment (PPE). The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with personal protective equipment including a range of disposable gloves, aprons and coverings. Staff were able to describe how they would use these to comply with the practice's infection control policy, for example, the use of disposable examination couch coverings. There were posters instructing staff on the action to take in the event of a needle stick injury.

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

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and the equipment we saw, such as scales and blood pressure testing equipment had been tested and appeared to be in good working order.

Staffing and recruitment

Personnel records confirmed that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and criminal record checks through the Disclosure and Barring Service. All GPs, nurses and staff who acted as chaperones had had criminal records checks. There were records to show that the professional registration checks for staff with the Nursing Midwifery Council or the General Medical Council had been completed.

The practice comprised a small staff team and the practice manager ensured that only one member of staff was on leave at any one time. The staff covered for each other's absences. The practice employed regular locum GPs. The practice had a recruitment policy that set out the standards it followed when recruiting any staff. There was a rota system for all the different staffing groups to help ensure

Requires improvement

Are services safe?

that enough staff were on duty. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors. These included annual and monthly checks of the building and its environment, medicines management, staffing as well as dealing with emergencies and equipment. There were health and safety processes. For example, there was a system governing security of the practice. Visitors were required to sign in and out using the dedicated book in reception and staff checked the identity of visitors. There was a lock on the door to the staff reception area to prevent unauthorised access.

Arrangements to deal with emergencies and major incidents

All staff were up to date with basic life support (BLS) training. Emergency medicines and emergency equipment were available. These had been checked regularly. However, there was no emergency medical oxygen equipment available. Therefore the practice could not show that they were equipped to adequately deal with medical emergencies that may arise from time to time. We discussed this with the GP at the inspection and since then the practice has secured an emergency oxygen kit. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. There were processes 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.

There were up to date business continuity plans to manage foreseeable events such as loss of utilities to the building, staff sickness and adverse weather. The documents contained relevant contact details for staff to refer to in the event they needed to take further action.

The building was a purpose built single story surgery and complied with the current fire safety regulations. Fire extinguishers were located at designated points and had been regularly serviced. Staff had completed fire safety training. However, there had not been any recent fire evacuation 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 patient care and 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. There were accurate and comprehensive assessments of patients on the anonymised records that we looked at. There were regular reviews of patient care and treatment in line with NICE guidance.

There was a range of nurse appointments available to patients. These included chronic disease management – such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). There were frequent appointments available. Patients were called for any necessary blood tests before their nurse appointment so that staff had all the information to hand before the consultation. There was one practice nurse who was led by the GPs in specialist clinical areas such as diabetes, heart disease and asthma.

The GP and the nurse we spoke with were open about asking for and providing colleagues with advice and support. For example, the GPs and the nurse met each day to discuss complex issues or clinical decisions. These meetings were not recorded but the GP was able to show how these discussions had benefitted individual patients and kept their own clinical practice under review.

Data showed that the practice's performance for antibiotic prescribing and for the prescribing of various pain killers was comparable to similar practices.

Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, managing child protection alerts and medicines management. All the staff had specific roles in calling patients for clinical reviews. The practice rarely sent letters to patients asking them to attend for reviews but telephoned the patients as they had found that this was more effective.

The practice had a system for completing clinical audit cycles. An audit that involved identifying patients over 65 who had a deficiency in the vitamin B12 had been carried out. The audit had been repeated three times during the previous 14 months and had resulted in a significant decrease in the numbers of patients over 65 who had a B12 deficiency. The GP told us that the practice used prescribing data to help ensure that the use of medicines such as painkillers, antibiotics and hypnotics were in line with current guidance.

The practice identified its frequent accident and emergency (A&E) attendees. In some cases reviews and treatment carried out by the practice avoided patients re-attending, in other cases attendance was unavoidable such as injury or complex medical history.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The practice scored highly for its ability to diagnose the common long-term conditions that were assessed by QOF. In this regard the practice had improved its own performance over the last few years and was consistently above the local and national averages. We looked at nine of the clinical areas covered by QOF. In all of them the incidence of diagnosis of the condition had improved and sometimes, as in the diagnosis of atrial fibrillation, markedly so.

However, the QOF results also showed a lack routine management of disease in those same areas. Routine management means such activities as medicines reviews and tests such heart and lung function. For example, in all the areas related to the routine management of diabetes the practice had experienced a drop in performance since 2012. This was also true in other areas such as chronic kidney disease and chronic obstructive pulmonary disease (COPD). For example, for two routine tests for patients with COPD the practice performance was in the bottom 5% nationally, there were similar results for some of the routine diabetic tests. This was not always the case, for atrial fibrillation, asthma and heart failure the record on completing routine tests was above both the local and national averages.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

There were two GPs both of whom were appraised annually. The practice nurse was appraised by the GPs as was the practice manager. Administrative staff were appraised annually. All the staff we spoke with about their appraisal said they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with the manager.

There was an overall training plan. Mandatory training such as fire safety, manual handling and safeguarding had been completed for most staff. Staff told us the practice nurse had completed safeguarding training but records were not available to confirm this. The practice nurse and the practice manager had completed chaperone training. Staff told us that they were able to access any relevant training.

Working with colleagues and other services

The practice worked with other professionals such as, district nurses, social services, GPs and other specialists. There were regular meetings with the palliative care service. These meetings discussed the medical needs of patients and included social, spiritual and family needs.

The practice received test results and information from other services electronically and by post. There were policies setting out how these were dealt with and staff were aware of them. For example, out- of- hours information was checked daily by the practice manager or named receptionist in their absence. In letters and reports items of text were highlighted for GPs to check and returned to the reception staff for action and filing. There were no reported instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Receptionist telephoned patients who had been discharged to establish if the practice could do anything to assist or simply as a "comfort" call. These patients received priority appointments. They were asked to telephone and speak to a GP if their condition changed to the point that they thought they needed to be admitted to hospital.

Information sharing

All information about patients received from outside of the practice was captured electronically in the patients' records. For example, letters received were scanned and saved into the patients' records by the practice. Information from the out-of-hours service (OOH) was received by fax or by e-mail and was scanned into patients' notes.

The practice used the Choose and Book system for patient referral to secondary care. (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). The practice had systems to provide patients 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. It had recently been upgraded and staff felt that the system of flags, whereby important information was displayed on the users screen, was very helpful in identifying certain patients such as those requiring routine tests.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment, such as implied consent. The policy stated how consent should be recorded. Consent was specifically recorded for any invasive procedures. Staff we spoke with understood the consent and decision-making requirements of legislation and guidance.

The GP we spoke with had received formal training in the Mental Capacity Act 2005 (MCA) and was aware of the implications of the Act. Reception staff had not had formal training in the Act but were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice. The GP told us that there had been no cause to hold any "best interest" meetings for patients who lacked the capacity to make decisions.

Patients with mental health problems were supported to make decisions through the use of care plans, which they were involved in agreeing. 90% of these care plans were reviewed annually. We were told that the other 10% had been seen during the previous year but had chosen not to have a care plan.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

Staff told us that all new patients were offered a health check. They were seen by a GP and the practice nurse was available at the same time to follow on any health issues identified by the GP for example, patients who were on repeat medicines.

There was a range of leaflets available to inform patients on health care issues. These included smoking cessation, diet and healthy living. There was more detailed information about long-term conditions including mental health, cancer and asthma. There were details of organisations that were available to help patients suffering from these, and other, conditions.

The practice also offered NHS Health Checks to all its patients aged 40-75. Staff told us of several instances in the last year when these checks had led to the early diagnosis of conditions for example high blood pressure.

The practice undertook other health prevention activity. In the previous year had identified and offered assistance to patients with chronic diseases who were smokers. The practice's results in this were in the top one per cent in the country. Over the last two years the practice had offered smoking cessation assistance to 90% of all the patients identified as smokers.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. During the last two years' the performance for child immunisations was 100% of all immunisations compared with the local clinical commissioning group (CCG) averages of 90 – 95%. The practice also did well in providing influenza vaccinations to the elderly and patients with long-term conditions achieving results that were better than the CCG and national performance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the national patient survey. This showed that patients felt they were treated with dignity and respect. Patients said that the GPs and nurse listened to them, explained tests as well as results and treated them with care and concern.

Patients completed comment cards to tell us what they thought about the practice. We received 27 completed cards and the all were positive about the service experienced. All the patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. This was a small practice and staff knew the regular patients well. The reception area was partitioned from the waiting area so that patients' conversations with the receptionists were confidential as were telephone calls coming into the reception. There were notices and flow charts on display to the reception staff guiding them on how to keep information confidential and how to deal with requests for information. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour, or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

There was a notice in the patient reception area stating the practice's zero tolerance of abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients said that the GPs and the nurse discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive. For example, we saw that nine out of ten mental health patients had a care plan which had been discussed and agreed with them. Patients said staff explained the care and treatment that was being provided and what options were available. Patients also received appropriate information and support regarding their care or treatment through a range of informative leaflets. The patient record system used by the practice enabled GPs and the nurse to print out relevant information for the patient at the time of the consultation.

Patients' comment cards and the patients we spoke with reported that they felt listened to. They felt the care was very good. They said that they were treated as individuals by staff who knew them well. Some patients commented on how quickly problems and referrals were acted on. We saw the process that was followed when a patient was referred to a secondary provider. Once the patient and GP had made the decision that referral to a secondary provider was required, the practice manager discussed with patient where they wanted to have the treatment or consultation and made the arrangements, there and then, with the patient using the Choose and Book system. The patient left the practice with all the arrangements completed and merely needed to confirm them with the receiving hospital or provider

Patient/carer support to cope emotionally with care and treatment

There was support and information for patients and their carers to help them cope emotionally with their care, treatment or condition. We heard reception staff explaining to patients and their carers how they obtain access to services such as those related to specific disabilities or conditions. There was written information available for carers to help ensure they understood the various avenues of support available to them. The patients we spoke with on the day and the comment cards we received highlighted that staff were compassionate as well as supportive and, on several occasions, commented that staff went beyond what the patients had expected of them.

There were notices in the waiting room informing patients how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was a carer or was otherwise in need of support. Reception staff telephoned patients with memory problems, shortly before the appointment time to help ensure they had not forgotten the appointment.

The GPs carried out home visits to patients who were housebound or receiving end of life care. There were end of life care plans. There was a policy to follow up with families who had suffered bereavement. This took the form of a telephone call to the family and the offer of consultation, at

Good

Are services caring?

a flexible time and location to meet the family's needs, and advice on how to find any support services. The records of partners and family members of deceased patients were flagged so that all staff were aware of any recent bereavement.

The practice manager and practice nurse carried out home visits to housebound patients to provide services such as influenza vaccinations and routine health checks. The practice manager accompanied the nurse because this provided housebound patients with an opportunity to comment on the practice performance and because some housebound patients said that it reduced their sense of isolation.

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 people's needs and had systems to maintain the level of service provided. The needs of the practice patient population were understood and there were systems to address identified needs in the way services were delivered. We heard staff making appointments. They were pleasant and respectful to the patients. They tried to accommodate the times that the patients asked for however, when they could not they talked with the patients to identify other suitable times. Patients had the choice of a male or female GP, though this was dependent on the working patterns of the GPs. Patients could request longer appointments if necessary..

The practice did not have a patient participation group (PPG). It had tried to generate interest in a group but had not been successful. The practice received comments and suggestions at the reception. There were NHS family and friends survey leaflets available that patients had completed but it was too early to draw any definite conclusions from the results. There were notices in the reception and in corridors asking patients to provide feedback about their care and treatment. The practice took into account the views and comments of patients. For example, as a result of suggestions the practice had implemented a late evening surgery one day a week for patients who had difficulty coming to the practice during working hours.

Tackling inequity and promoting equality

Disabled patients could access the practice. There was a ramp leading to the front door so that patients in wheel chairs could use it. The waiting area was large enough to accommodate patients with wheelchairs as well as 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 were translation services available if required though staff told us the services were rarely needed.

All patients who had a diagnosis of dementia were flagged on the practice's computer system. When staff accessed these records a message came up on the screen informing them of the diagnosis. This helped ensure that all staff were informed and aware so they could provide relevant support to patients.

Access to the service

The practice was open for 9am to 6pm but closed between 12 noon and 3pm to allow staff to process administrative work without interruptions, during this time patients were referred to the out of hours services. The appointment system allowed for urgent cases, same day appointment's and telephone consultations. There were appointments available to see male or female doctors. Comprehensive information was available to patients about appointments in the practice leaflet. There were also arrangements to help ensure patients received urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave the contact details of other relevant out- of- hours services.

Patients were generally satisfied with the appointments system. In surveys, more than 90% rated their experience of making an appointment as good or very good. Patients told us they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. They said it was easy to obtain suitable appointments and this was confirmed by remarks made on the comment cards. The practice's extended opening hours on Fridays until 7.30pm, were particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

There was a complaints policy that included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage all complaints. We looked at the complaints log. There had been learning from complaints. For example, records of a complaint which concerned the handling of patient information acknowledged the way in which it could have been better managed. Records demonstrated staff learning as a result of this complaint.

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 staff we spoke with told us they felt well led and described a practice that was open and transparent. Staff consistently said they understood what the practice stood for. For example, trying to ensure that patients saw their own (preferred) GP whenever possible and trying to respond to patients needs to the best of their ability at all times. The GPs and the manager said they advocated an "open door" policy and all staff told us the GPs and practice manager were very approachable.

There was had been discussion amongst the GPs and staff about the strategic direction of the practice and there had been informal discussions with other health professionals about how the practice might develop.

Governance arrangements

There was a range of mechanisms to manage governance of the practice. The policies we looked at were in date and staff had access to all policies through a computerised system. There were regular meetings between staff at lunch time each day when the practice was closed to patients. There were no minutes of these but we were told that at these meetings day to day problems were resolved informally and staff were able to give examples of how these discussions had befitted individual patients as well as kept their own clinical practice under review.

There were formal practice meetings quarterly. We looked at the minutes of these for the last year. Relevant issues were raised and acted upon. For example, there had been guidance about the use of aspirin in cases of chest pain and the practice had acted on the guidance. The minutes showed that staff were informed about changes to practice and had the opportunity to contribute to the safe running of the practice. Clinical governance was discussed at the practice meetings. For example, there had been discussions about the use of protocols and templates to improve the management of diabetes.

The practice had an on-going programme of clinical audits which it used to monitor quality as well as systems to identify where action should be taken. There had been an audit of patients with chronic constipation. This had resulted in changes to medicines, dietary advice such as fibre intake and patient education. There were processes to manage risk, for example. There were paper copies of appointments printed each day when the practice closed so that, in the event of computer failure, the practice's daily work could begin. Other risks such as fire, flood, staff illness and inclement weather had also been considered and there were written procedures to follow in the event of these occurring.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. All the staff had responsibility for different activities. For example, checking on QOF performance.

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

Staff we spoke with felt that the practice was open to suggestions from staff. They said they were made aware of comments and complaints through the meetings that were held and through emails. There was a suggestion box in the waiting room. It was through patient suggestions that the practice had instigated additional opening hours on Friday evenings.

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 staff files and saw that regular appraisals took place. There were records of the training that was identified at staff appraisals and there were plans to address these.

The practice had completed reviews of significant events and other incidents and had shared the findings with staff at meetings to help ensure the practice improved outcomes for patients. For example, there was learning from problems with the information technology system, with staff now more able to be flexible in the event of computer failure. However there was no common understanding of how to identify and report a significant event.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person has failed to establish and effectively operate systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity Because There was no policy to guide staff on what was a significant event or incident, therefore there was no common understanding of how to identify and report a significant event or incident. This was contrary to Regulation 10 (1) (a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 And Regulation 10 (2) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 And is now contrary to Regulation 17 (1) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014