Kingsway Medical Practice

Quality Report

720 Burnage Lane,
Manchester
M19 1UG
Tel: 0344 477 3625
Website: www.kingswaymedicalpractice.co.uk

Date of inspection visit: 15/07/2015
Date of publication: 27/08/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kingsway Medical Practice on 15 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and safe services. It was also good for providing services for the populations groups we rate. We found however the service required improvement in well led.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. 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 provided varied feedback on accessing appointments, with a number of patients reporting difficulties getting routine appointments with a GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was no clear strategy in place to govern the practice following changes in the structure and capacity of the partnership.

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

Importantly the provider must

- Ensure effective systems and processes are in place to make sure they assess and monitor their service for quality, safety and to maintain staff well-being at a partnership level following changes in the capacity and structure of the GP partnership.

Summary of findings

- Ensure staffing levels are planned, reviewed and checks are place to ensure staff do not work excessive hours.

In addition the provider should,

- Ensure policies and procedures to govern activity and support staff are in place and reviewed in a timely manner.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated via team meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. 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 average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans being in place for staff.

Are services caring?

Good

The practice is rated as good for providing caring services . Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services . The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients' reports varied in relation to accessing appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. There was no up to date vision and strategy following changes in the partnerships capacity. There was a leadership structure and most staff felt supported by management but at times there wasn't the

Summary of findings

capacity within the management team to resolve issues which resulted in staff regularly working overtime. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and some were not in place such as recruitment and selection of staff. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and appraisals, with the exception of the practice manager.

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 of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework.

The practice participates in the Avoiding Unplanned Admissions scheme providing those patients at risk with individual care plans. Those vulnerable patients are discussed weekly with district nurses and reviewed fortnightly as part of multi-disciplinary team meetings with other health and social care providers. These patients also have access to same day telephone consultation with a GP and where required appointments would be arranged. Home visits are available for all housebound patients.

The practice had achieved 70% vaccination rate for the influenza vaccine for those over 65.

People with long term conditions

Good

The practice is rated as good for the care of of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so their condition could be monitored and reviewed.

The national Quality Outcome Framework (QOF) 2014/15 showed the majority of clinical and public health outcomes had been achieved, with improvements being made on the previous year for conditions such as chronic obstructive pulmonary disease (COPD) and diabetes. A diabetic specialist nurse holds monthly clinic at practice for complex diabetic patients.

Patients at high risk of emergency admission had care plans in place and were contacted regularly. Patients at high risk had same day access to a GP to avoid emergency admission into hospital.

Patients with COPD or asthma were provided with personalised management plans to help in the event of exacerbation.

Summary of findings

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations. Where children and babies failed to attend for immunisations these would be followed up by the practice nurse.

All reports from Accident and Emergency (A&E) for all patients under 16 years are sent to relevant GPs for review to assist in identifying any recurring attendance at A&E and/or any possible safeguarding issue.

Appointments were available outside of school hours for children and all of the staff were responsive to parents' concerns and would ensure parents could have same day appointments or telephone consultations for children who were unwell.

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 practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation and weight management. Access to NHS health checks was promoted to patients when the service was in the local area and national screening programmes such as bowel screening were promoted.

Appointments and prescriptions could be booked online in advance. Telephone consultations were also available to patients who could not attend the practice.

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 carried out annual health checks for people with learning disabilities and offered longer appointments for people when required. For patients where English was their second language, an interpreter could be arranged.

The practice held a register of carers and there was a dedicated notice board for carers in the waiting area.

Summary of findings

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

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 maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

One GP was the Clinical Commisioning Group (CCG) lead for dementia. Any patient who was at risk of dementia had been identified by the practice and screening was carried opportunistically and memory clinics had been introduced at the practice. A consultant undertook a monthly clinic at practice to support the care and treatment of those patients with complex dementia.

Special care alerts were placed on vulnerable patients notes to alert reception staff. Same day appointments were offered where required.

The patient participation group (PPG) staged meetings at the practice for carers of dementia patients so they can discuss issues they have and enjoy guest speakers.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with ten patients. We reviewed seven CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2014/15 and noted 79% described their overall experience of this surgery as good and 94% had confidence and trust in the last GP they saw or spoke to., slightly below the local and national average.

Areas for improvement

Action the service MUST take to improve

- Ensure effective systems and processes are in place to make sure they assess and monitor their service for quality, safety and to maintain staff well-being at a partnership level following changes in the capacity and structure of the GP partnership.
- Ensure staffing levels are planned, reviewed and checks are place to ensure staff do not work excessive hours.

Action the service SHOULD take to improve

- Ensure policies and procedures to govern activity and support staff are in place and reviewed in a timely manner.

Kingsway Medical Practice

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, practice manager specialist advisor and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Kingsway Medical Practice

Kingsway Medical Practice provides primary medical services in South Manchester, from Monday to Friday. The practice is open between 8.30am – 6.00pm Monday to Friday, with the exception of Wednesday when the practice closes at 4:00pm.

Kingsway Medical Practice is situated within the geographical area of NHS South Manchester Clinical Commissioning Group (CCG).

The practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Kingsway Medical Practice is responsible for providing care to 5800 patients of whom 48% were male and 52% were female, with 12% black and minority ethnic (BME) patients.

The practice consists of five GPs, two male and three female, a nurse practitioner, practice nurse and health care assistant. The practice was supported by a practice manager, receptionists, secretaries, practice administrator and a clerical assistant.

When the practice is closed patients were directed to the out of hour's service GoToDoc.

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 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

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 15 July 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with ten patients and seven members of staff. We spoke with a range of staff, including the GPs, practice manager, nurse practitioner, practice nurse and reception staff.

We reviewed seven Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

Detailed findings

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)

Good

Are services safe?

Our findings

Safe Track Record

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

We reviewed safety records, incident reports and spoke with staff who confirmed incidents were routinely discussed. This showed the practice had managed these consistently over time and demonstrated a safe track record over the long term.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, We saw from the practice significant events records and speaking with staff investigations had been carried out, however the practice would benefit from taking a holistic approach to investigating significant events. We noted from records investigation had taken place either from a clinical perspective or administration perspective even where incidents had involved potential gaps in both areas. Speaking with the practice they acknowledge the gaps and told us they would incorporate all aspects of service delivery. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurses told us they received regular updates as part of their ongoing training. They also undertook self-directed learning and attended learning events.

Reliable safety systems and processes including safeguarding

The staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a child protection and vulnerable adults' policy and procedure. We noted the procedure was displayed for staff within clinical and administration areas. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead and they had completed adult and children's safeguarding training. Clinical staff were to complete additional safeguarding training on areas such as Mental Capacity Act and domestic abuse in October 2015. All other staff had completed safeguarding training and provided evidence and examples of having a clear understanding of their safeguarding responsibilities.

Chaperones were available for patients with notices informing patients of their rights to ask for a chaperone within the waiting area and clinic rooms.

Medicines Management

The practice held medicines on site for use in an emergency or for administering during consultations such as administering of vaccinations.

The nurse practitioner was qualified as an independent prescriber and received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which they prescribed. The nurse and nurse practitioner administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse and advanced practitioner had received appropriate training to administer vaccines.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

Good

Are services safe?

The practice worked alongside the Clinical Commissioning Group (CCG) medicines management team who supported the practice to look at prescribing within the practice and audit medicines such as those prescribe for patients with asthma to ensure they are following up to date prescribing guidance.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals, such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

We saw prescriptions for collection were stored behind the reception desk, out of reach of patients. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was seen to be clean and tidy. A nurse had recently taken the lead for infection control.

Contract cleaners were in place and attended the practice every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis and the practice held a copy. We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw the dignity curtains in each room were disposable and labelled showing when they required replacing.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice. The policy stated infection control training would take place annually for staff and an annual audit would take place. We noted new staff had undertaken infection control as part of their induction and the new nurse lead was due to undertake an update. An audit had not taken place since 2011; however the practice was looking to work with the local CCG to undertake an audit.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single patient use instruments and we saw these were stored correctly and stock rotation was in place.

Equipment

The practice manager ensured all equipment was effectively maintained in line with manufacturer's guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

A panic alarm system was in place in consulting rooms and behind reception for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. However there was no formal recruitment and selection policy and procedure in place. We looked at the recruitment and personnel records of five staff. We saw in these records that checks of the person's skills and experience through their application form, personal references, identification, criminal record and general health had been carried out. We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Where relevant, the practice also made checks to ensure that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

Good

Are services safe?

to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice manager had staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; however we were told due to current staffing levels annual leave was not always covered for example the practice nurse. We were told that staff were regularly working additional hours including weekends to manage the current work load; we saw for example one member of the administration team had over 450 hours owed. There was no policy in place for staff working overtime. Staff told us wherever possible they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and resuscitation equipment. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance form the Resuscitation Council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

The business continuity plan was in the process of being up dated and we were told all partners will hold a hard copy off site and one will be held in reception to ensure robust systems are in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines.

The GPs and practice nurse we spoke with explained how they reviewed patients with chronic diseases such as asthma on an annual basis. The national Quality Outcome Framework (QOF) 2013/14 showed that the majority of clinical outcomes had been achieved, but were below the local CCG and national average. For example 63% of outcomes for patients with chronic obstructive pulmonary disease (COPD) had been achieved, 28% below the local average and for patients with diabetes 70% of outcomes had been achieved, 18% below the local average. The practice was aware of the lower than average outcomes and had worked to improve the outcomes during 2014/15. An improved recall system had been introduced for patients with long term health conditions. Looking at data provided by the practice for 2014/15 we saw that outcomes for patients had improved for example 85% of outcomes had been achieved for patients with COPD. The practice were continuing in the current year to look at ways of improving outcomes for all patients in line with QOF and initial in year data showed on-going improvement.

GPs carried out annual physical health reviews for patients diagnosed with mental health needs, including those with schizophrenia, bi-polar and psychosis, as a way of monitoring their physical health and providing health improvement guidance. The QOF 2013/14 showed lower than average outcomes were being achieved, for example 23% had a comprehensive care plan documented 63% below the local average. The practice had worked to improve these outcomes and data for 2014/15 showed 97% of all outcomes for patients with poor mental health had been achieved and in the current year 2015/16 66% of reviews had already taken place.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nurses told us they received regular updates as part of their ongoing training.

Clinical staff were able to describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act (MCA) 2005, with GPs due to attend training to ensure MCA was embedded into practice.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place as part of the cancer improvement scheme to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held monthly with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs and ensured that whenever possible patients die in the place of their choosing.

We were told for patients where English was their second language an interpreter could be booked in advance or accessed via the telephone. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes and COPD.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments. The practice nurse provided a range of examples of patient information leaflets they provided to patients to self-manage conditions such as COPD and asthma.

Good

Are services effective?

(for example, treatment is effective)

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We saw audits including medicines management of asthma.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 99% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF indicated the practice had below average level of achievement with 82% of outcomes achieved 9% below those of other practice within the local CCG area in 2013-2014. Reviewing data provided by the practice for 2014-2015 we saw an overall improvement in outcomes.

Patients told us they were happy with the way doctors and nurses at the practice managed their conditions and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support and safeguarding. We noted a good skill mix among the GPs and nurses with a number having additional training and qualifications. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Speaking with staff and reviewing records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively. The practice had an appraisal system in place for all staff.

The nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example on administration of vaccines, cervical cytology and treating minor ailments. Staff told us they received updates and new guidance during team meetings.

All staff we spoke with told us overall they were happy with the support they received from the practice, however recently in light of changes at partnership level, staff shortages and a high turnover of reception staff, communication could be improved to keep staff up to date with the on-going situation and to understand the impact increased workload had on staff. We were also told that the current nursing hours were not sufficient to meet patient's needs, with a current waiting time of four weeks for an appointment with the practice nurse. Speaking with the practice they were aware of the need for additional nursing hours and were working to resolve this.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Multi-disciplinary meetings were arranged with other health and social care providers, for example weekly meetings took place between GPs and district nurses. Communication took place on a daily basis with community midwives, health visitors and district nurses by telephone and fax.

The practice worked with other service providers to meet patients needs and to manage patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely

Good

Are services effective?

(for example, treatment is effective)

manner. The practice sent referrals directly to a central referral unit and those referrals such as two week wait referrals were sent electronically. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The GPs described how the practice provided the out of hours service with information to support, for example, end of life care. Information received from other agencies, for example accident and emergency or hospital outpatient departments were seen and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC which was shared with local care services and out of hour providers.

Consent to care and treatment

A protocol was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, recording consent, consent from under 16s and consent for immunisations, however the protocol did not provide guidance for staff, where assessing capacity in line with the Mental Capacity Act 2005.

Speaking with staff they were clear about their responsibility to gain and where required record consent. We found staff were aware of the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). The GPs were due to attend training to ensure MCA was embedded into practice.

All clinical staff we spoke with made reference to Gillick competency when assessing whether young people under 16 were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person understands of the proposed treatment and consequences of agreeing or disagreeing with the treatment. Where capacity to consent was unclear staff would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were offered an appointment for a health check and an appointment made with a GP for any new patients on regular medication.

The practice had a range of written information for patients in the waiting area which could be taken away on a range of health related issues, local services health promotion and support for carers.

We were provided with details of how staff promoted healthy lifestyles during consultations. During discussions with GPs and nurses it was clear they were aware of supporting patient's physical, emotional and social needs to enable healthy lifestyles.

The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The nurses and health care assistant provided lifestyle advice to patients this included dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 77% vaccination rate for the influenza vaccine for those over 65.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by an administrator.

The practice's performance for cervical smear uptake was 79.8%, just below the local (81.7%) average.

Good

Are services effective?

(for example, treatment is effective)

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, details were passed onto the GP and where any follow up was required staff would arrange an appointment or home visit.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with ten patients and reviewed seven CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out process if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk to maintain privacy.

We observed staff speaking to patients with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in a private area.

Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 85% of respondents found the receptionists at this surgery helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones and modesty sheets to maintain patients' dignity.

We found all rooms had dignity screens and lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

Patients told us they were happy to see any GP or nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey, 94% had confidence and trust in the last GP they saw or spoke to and 92% had confidence and trust in the last nurse they saw or spoke to.

The practice had formal care plans in place for patients and they included care plans for vulnerable patients over 75 year of age and those patients at risk of unplanned hospital admissions.

We noted where required patients were provided with extended appointments. For example reviews with patients with learning disabilities, those who required an interpreter or had multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke with were articulate in expressing the importance of good patient care and also had an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 85% of respondents stated the last GP they saw or spoke with was good at listening to them, 82% say the last GP they saw or spoke with was good at giving them enough time and 82% said the last nurse they saw or spoke with was good at giving them enough time.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice worked with patients and families and also worked collaboratively with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as opportunistic screening and reviews, accommodating home visits, booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients via the website and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice had a patient participation group with 400 virtual members and two members who met with the practice face to face to discuss practice issues. The practice used a variety of methods to engage members such as face to face and email.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example longer appointment times were available for patients with learning disabilities or those who required an interpreter.

The practice was able to book face to face translators for Non-English speaking staff in advance of appointments or access interpreters over the telephone if required.

The practice was accessible for patients with disabilities. A disabled toilet was available as were baby changing and breast feeding facilities.

There were male and female GPs in the practice therefore patients could choose to see a male or female doctor.

Access to the service

The practice was open between 8.30am – 6.00pm Monday to Friday. Appointments were with a GP, Nurse or Health Care assistant 9:00am – 11:00am and 4:00pm – 6:00pm Monday to Friday with the exception of Wednesday afternoon when no GP appointments were available, and the surgery closed at 4:00pm.

All consultations were by appointment only and were pre-bookable up to four weeks in advance. For patients requiring same day access, appointments were reserved for patients who requested urgent medical attention. All same day appointment were with the nurse practitioner, who was able to treat minor ailments. If following the initial assessment by the nurse practitioner patients were required to see a GP they would be offered a same day appointment with the on call GP.

Patients' views on the appointment system varied with patients reporting the system to be confusing. Some patients reported making on the day appointments with the nurse practitioner in order to see a GP or in some situations would bypass the GP practice and visit a walk in centre or Accident and Emergency.

We were told vulnerable patients for example those at risk of unplanned hospital appointments would be offered urgent appointments with the on call GP and children over 12 months would be offered same day appointments with the nurse practitioner, and those under 12 months would be seen by the duty GP.

We saw from the GP national survey 83% were able to get an appointment to see or speak to someone the last time they tried (83% CCG average), 64% of respondents describe their experience of making an appointment as good (69% CCG average) and 47% of respondents with a preferred GP usually get to see or speak to that GP, lower than the local CCG average 58%.

Information was available to patients about appointments on the practice website. This included information about the appointment system and home visits.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was

Good

Are services responsive to people's needs?

(for example, to feedback?)

closed and this information was detailed on the practice website. If patients called the practice when it was closed their call would be automatically diverted to Go to Doc, their out of hours provider.

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented. Lessons learned were shared with staff at team meetings.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so. Reception staff told us they would give patients the option of speaking with the practice manager at the time for any verbal complaints or issues they felt could be resolved informally, however there was no system in place for recording and monitoring verbal complaints.

Are services well-led?

Requires improvement

(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 mission statement in place 'Kingsway Medical practice welcomes patients from all sections of the community, regardless of age, race, religion or sexual orientation'.

Following changes within the partnership, with GP partners reducing hours, we found there was reduced capacity within the management structure and no clear vision or strategy in place following these changes. The business plan had not been updated since 2013 in light of the changes. We were told the recent changes had been compounded by staff sickness and were creating challenges in the management of the practice, for example covering staff sickness, staff working weekends and policies and procedure were not always in place for example recruitment.

We spoke with seven members of staff and they all expressed their understanding and commitment to the practice mission statement, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. We looked at several of the policies and saw these reflected current guidance and legislation, however a number were due to be reviewed and some policies were not in place.

There were named members of staff in lead roles. For example there was a newly appointed lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they knew who to go to in the practice with any concerns.

We saw the practice made use of data provided from a range of sources including the clinical commissioning group (CCG) and General Practice Outcome Standards (GPOS) to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance.

The practice manger and GP partners met weekly to discuss practice issues and practice development, however we were told this time was not sufficient to cover all the on-going issues such as staffing levels and staff cover. These meeting were not minuted. Full practice meeting were held every six weeks and these were minuted and accessible to staff via the computer system.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place. The GPs within the practice conducted individual clinical audits, in which outcomes were shared to monitor quality and share learning.

The practice had arrangements for identifying, recording and managing risks associated with the premises and equipment. The practice manager provided us with details of maintenance and equipment checks which had been carried out in the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines. Leadership, openness and transparency

Staff told us that there was an open culture within the practice and in the main they had the opportunity and were happy to raise issues with GPs or the practice manager. However recent pressures, capacity and changes had meant time was not always available to discuss issues face to face and staff felt they would welcome more opportunities to be involved in practice developments. We were told however when needed there was never a time when there was no one available to seek support, advice or guidance. Speaking with the advanced nurse practitioner they told us whenever they required support during a consultation GPs were available and a secure IT system was in place to allow the nurse to message GPs regarding patient care and seek guidance.

The practice manager was responsible for human resource policies and procedures. There was no formal recruitment policy and procedure in place, despite a high turnover of staff and the recent recruitment of reception staff. We reviewed staff files for recently recruited staff and found evidence of appropriate checks and safeguarding having

Are services well-led?

Requires improvement

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

been in place for example two references. We saw an induction process was in place for new staff which included staff handbook, policies and procedures and confidentiality.

All staff were able to access policies and procedure and staff handbook via the internal computer system. They included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies and new members of staff confirmed they formed part of the induction process. We noted however there were no policies or guidance in place for staff where they were required or worked overtime.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, compliments and complaints. The results of GP national survey 2014 were shared with members of the virtual patient participation group (PPG), who were encouraged to contribute to the action plan.

We saw that there was a complaints procedure in place for formal complaints. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff. However there was not system in place for reviewing or monitoring verbal complaints made to the practice.

We reviewed the results of the GP national survey carried out in 2014/15 and noted 79% described their overall experience of the practice as good (83% CCG average) and 72% would recommend this surgery to someone new to the area (76% CCG average), both below the local CCQ average.

Staff told us in the main they were able to give feedback and discuss any concerns or issues with colleagues and management, however recent challenges in light of changes within the partnership had sometimes impacted on timely communication and resolution of issues. For example support for the nursing staff to manage the demands on their time. Staff told us overall they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and development opportunities and appraisals were up to date for staff with the exception of the practice manager.

The practice had reviewed significant events and other incidents and shared with staff.

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 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. **Why the provider was not meeting the regulations:** **Capacity and staffing levels had not been reviewed or adapted to respond to the changing needs and circumstances of people using the service or the changes within the structure of the partnership. Checks had not been put in place to ensure staff were not working excessive hours to meet demands.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; **Why the provider was not meeting the regulations:**

This section is primarily information for the provider

Requirement notices

The provider was not operating effective governance systems and processes to make sure they assess and monitor their service for quality, safety and to maintain staff well-being at a partnership level following changes in the capacity and structure of the GP partnership.