Arlington Road Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 Arlington Road Medical Practice on 2 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, responsive, caring and well led services. However it was rated as requires improvement in relation to providing safe services. The practice was rated as good for providing services to people with long term conditions, families, children and young people, working age people, people whose circumstances make them vulnerable and for services for people with mental health problems including those with dementia.

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

- The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.
- Patient feedback was overwhelmingly positive. Patients said they were treated with compassion, dignity and respect. They said they felt listened to and that they were involved in decisions about their care and treatment.
- Systems were in place to ensure high standards of cleanliness and infection control and patients said the practice was always clean and tidy.
- The practice provided additional services to its own patients and those from other practices over and above routine GP services, which included community dermatology and ear micro suction.
- The practice had implemented innovative approaches to improving services to patients. For example, by designating one single GP to undertake all home visits during the day, the practice had been able to extended appointment times for patients to 15 minutes. This gave patients more time and allowed GPs to undertake checks for long term conditions

Summary of findings

opportunistically. Also, as a result of being able to start home visits earlier in the day, inappropriate calls to the paramedics and hospital admissions had been avoided.
- There was a strong philosophy of investment in its services to improve patient care. The practice had recently invested its own funds to refurbish the practice premises and build and on site pharmacy. As a result the premises provided a modern, well equipped facility for patients and staff.
- The practice pro-actively identified and managed patients with dementia. The practice had a high diagnosis rate and had been better able to support these patients with their health needs and help them make decisions about their future care, including end of life planning.

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

Specifically, the provider must:

- Carry out a formal risk assessment for using medical chaperones who had not received a criminal record check undertaken with the Disclosure and Barring Service (DBS).

In addition the provider should:

- Put arrangements in place to ensure significant events, performance, quality and risks are regularly discussed at practice meetings and that minutes are kept.
- Ensure all staff have an annual appraisal which is agreed and documented.
- Clarify the leadership structure so that lead roles and responsibilities are clearly identifiable.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. There was evidence that significant events were recorded and communicated to relevant staff. It was clear that the lessons learned were shared and used to support improvement. There were sufficient staff to provide a safe level of service. However, the practice had not undertaken a formal risk assessment as to whether a criminal record check with the Disclosure and Barring Service (DBS) was required for non-clinical staff acting as medical chaperones.

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 were familiar with guidance from the National Institute for Health and Care Excellence and used it where appropriate. This included assessment of mental capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. All staff with the exception of administrative and reception staff had an up to date appraisal. All staff said that they felt well supported in their roles and had the training and development they required. There was evidence of multi-disciplinary working.

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were positive.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with a GP, and that urgent appointments were available the same day. The practice had re-designed it services to allow patients 15 minutes for each appointment. The practice had a recently been refurbished to provide 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a strong ethos for providing high quality care to patients and investing to improve its services and the staff we spoke with were able to articulate this. The practice did not have a clear, documented leadership structure; however, staff felt supported by management and knew who to approach with issues. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions but not all staff had received regular performance reviews. All staff attended meetings and staff events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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 and end of life care. It was responsive to the needs of older people, and offered home visits. The GPs made regular visits to provide support to people living care homes and nursing homes. The practice identified older people who were at risk of admission to ensure they had a care plan.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice undertook proactive case-finding to identify patients and ensure that they were followed up appropriately. Patients had structured and co-ordinated annual reviews to check their health and medication needs were being met. The practice had a long established service for patients with diabetes who had an annual appointment with one of three GP diabetes specialists in the practice as well as a mid-year review with their own GP or a specialist GP depending on their needs.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children identified as at risk and the GPs attended case conferences when required. All staff had received training on child protection and were aware of their roles and responsibilities in relation to this. There was evidence of joint working with health visitors. The practice had high levels of childhood immunisations done mainly by the practice nurses. The practice's duty doctor system allowed children to be seen straight away if necessary and directly after school.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice offered a full range of health promotion and screening which reflected the needs for this age group. The practice offered an automated booking service and on line ordering for repeat

Summary of findings

prescriptions. It was noted that the practice did not offer extended hours. However, the 84 per cent of respondents to the 2013 national GP survey said they were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours, this was above the national average.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had identified it patients who were vulnerable as those who had a learning disability, homeless people and those who had problems with drug and alcohol misuse. It encouraged these patients to have regular screening and physical health checks.

The practice regularly worked with multi-disciplinary teams in the management of vulnerable people. It signposted vulnerable patients to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse and understood their responsibilities in relation to reporting concerns about children and vulnerable adults.

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had a GP that specialised in dementia and had been proactive in identifying dementia patients on its register, particularly those that might be overlooked in residential care. The practice identified that the number of patients with dementia on its register was three and a half times the national average. The practice had been able to achieve a significantly higher than the Southern England average diagnosis rate for dementia. As a result it had also been better able to support these patients with their health needs and help them make decisions about their future care, and participate in end of life planning. For working age people the practice made regular referrals to a primary care mental health service based on its premises that provided patients with access to psychological therapies.

Summary of findings

What people who use the service say

We reviewed 32 comment cards where patients and members of the public shared their views and experiences of the service. Patient feedback was overwhelmingly positive. Patients described the service as outstanding and excellent. They said they were treated with compassion, dignity and respect. They said they felt listened to and that they were involved in decisions about their care and treatment.

We reviewed the most recent data available for the practice on patient satisfaction. Results of the 2013 national GP survey showed the practice amongst the best in a number of areas. For example, 92 per cent of respondents said they would recommend their practice. The results of the practice's own patient survey undertaken this year showed similar positive results. For example, 96 per cent of respondents rated the support and care provided by the nursing team as excellent or good.

Areas for improvement

Action the service MUST take to improve

- Carry out a formal risk assessment for using medical chaperones who had not received a criminal record check undertaken with the Disclosure and Barring Service (DBS).

Action the service SHOULD take to improve

- Put arrangements in place to ensure significant events, performance, quality and risks are regularly discussed at practice meetings and that minutes are kept.
- Ensure all staff have an annual appraisal which is agreed and documented.
- Clarify the leadership structure so that lead roles and responsibilities are clearly identifiable

Arlington Road Medical Practice

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.

Background to Arlington Road Medical Practice

The practice is situated near the centre of Eastbourne and provides general medical services to approximately 11,755 patients. There are eight GP partners and one salaried. The practice is a training practice and has two GP registrars. There are seven male GPs and three female. The practice also employs five practice nurses and two health care assistants. Opening hours are Monday to Friday 8.30am to 6pm. The practice provides a wide range of services to patients including clinics for asthma, diabetes, antenatal care, cervical screening, contraception, child immunisations, coronary heart Disease (CHD), travel vaccinations, stroke monitoring, health awareness and smoking cessation. The practice also provides minor surgery, dermatology and ear micro suction.

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

The practice looks after the one of the oldest populations in England with a significantly higher than average number of registered patients above the ages of 65, 75 and 85. It also has a large number of patients in residential care.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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 and asked other organisations including the Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG), NHS England and Health Watch to share what they knew.

Detailed findings

During our visit we spoke with a range of staff including, the GPs, the practice manager, the practice nurses, administrative staff and receptionists. We examined practice management policies and procedures. We spoke with representatives from the practices patient participation group (PPG). We spoke with three patients. We also reviewed 32 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had systems in place to ensure that safety incidents, concerns, complaints and near misses were reported, recorded and acted upon. All the staff we spoke with understood their responsibilities in relation to this. They all knew how to raise and report concerns, incidents and near misses.

We looked at significant event and complaints records for the last year. We saw that the practice reviewed and acted on issues raised and used them to improve safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. Records identified the date, the details of the event, the learning that had taken place and the action implemented as a result. The GPs told us that significant events were usually discussed and shared at monthly practice development afternoons or by email. It was clear from the significant events record that the details and learning was shared and that actions had been implemented as a result. The staff we spoke with were able to provide us of examples to demonstrate that this was the case. We also saw notes from a practice development meeting which showed that significant events were usually discussed at this forum. However, we were told that over the last year significant events had not been discussed as regularly as planned at this meeting, because a multidisciplinary meeting had recently been included which meant there had been insufficient time. However, we saw evidence that the practice had re-structured its meeting schedule to rectify this and ensure there was protected time to discuss significant events on a regular basis.

The practice had a system for ensuring all external safety alerts were responded to appropriately. All incoming alerts were reviewed by the practice manager who ensured that information was disseminated to relevant staff and that appropriate action was taken. We saw evidence that action had been taken as a result.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures in place to safeguard children and vulnerable adults which included the contact details for the designated adult and child safeguarding leads in the practice and the clinical commissioning group. All staff had access to these policies via their computer desktop. The practice had designated GP leads for both child and adult safeguarding who had had the necessary training to enable them to fulfil their roles. Training records showed that all other staff had undertaken training on safeguarding relevant to their role. All staff were aware of their roles and responsibilities in relation to safeguarding in general practice. They were able to describe the types of signs and symptoms of potential abuse and knew who to contact if they had concerns.

The practice had a chaperone policy in place and the details of how to access this service were posted on the walls in the consulting rooms. This allowed patients to have someone else present for any consultation, examination or procedure if they wished. This could be a family member or friend or a formal chaperone from the practice's clinical team. We saw that staff who undertook chaperone duties had undertaken appropriate training for the role.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

There was a protocol for repeat prescribing which was in line with national guidance and that was followed by the GPs. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Requires improvement

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and cascade training to other staff. The practice had undertaken an audit of infection control and there was evidence that improvements had been implemented as a result of the findings.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to implement control of infection measures. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms although not all the dispensers were wall mounted.

Equipment

We observed that the practice had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records to show that equipment was tested and maintained regularly. We saw evidence of calibration of relevant equipment, for example weighing scales.

Staffing and recruitment

The staff records we looked at showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS) for all clinical staff. However, there was no written risk assessment as to why DBS checks had not been undertaken for administrative and reception staff. These staff sometimes undertook chaperone duties which could involve them being left alone with patients.

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 ensure patients were kept safe. The GPs told us that they had a system in place for covering each other's leave which meant they rarely had to employ locums. This ensured continuity of care for patients. The practice had undertaken an analysis of patient demand to identify how many doctor sessions they needed a day so it could ensure there were enough staff to meet patients' needs.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There were two staff representatives for health and safety and an up to date health and safety policy. All new staff received a health and safety induction. The practice had undertaken an up to date health and safety audit of the premises which identified areas of non-compliance and the action required. There was evidence that actions had been implemented.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. We saw evidence that all staff had received up-to-date training in basic life support appropriate to their role.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were also available. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had arrangements in place to deal with foreseeable emergencies. We saw that there was a comprehensive and up-to-date business continuity plan in place. The plan outlined the arrangements to deal with foreseeable events such as loss of energy supplies, severe weather, loss of the computer system and essential data and fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were discussed and disseminated.

The GPs told us they lead in specialist clinical areas such as diabetes, dementia and dermatology. The practice nurses also had lead roles in areas such as childhood immunisations, asthma and chronic obstructive pulmonary disease (COPD) & travel health. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

Management, monitoring and improving outcomes for people

The practice showed us five clinical audits that had been undertaken over the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice undertook an audit to determine whether it was meeting national guidance in relation to immunisation regimes for patients with human, immuno-deficiency virus (HIV). The audit revealed a low success rate for one particular immunisation and as a result the practice introduced a new system for monitoring and recalling HIV patients to ensure they were up to date with all the recommended immunisations. As a result of this the practice was able to demonstrate an improved rate of uptake. The GPs told us that clinical audits were discussed and shared at monthly GP meetings.

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. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had two GPs who it had designated to take the lead on QOF. These GPs were given protected time to review performance against the QOF and actively identify where action was needed to ensure patients were receiving the best care and treatment. As a result, in 2013/14 the practice achieved 99 per cent of the total QOF point available to it. It met or exceeded all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease. For example, 95 per cent of patient with diabetes, on the practice register had had influenza immunisation.

The practice also participated in local benchmarking run by the clinical commissioning group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example, the practice used comparative data from the CCG on a daily basis to analyse on admissions to accident and emergency. From this it identified that its admissions were below what was expected.

Effective staffing

The training records we looked at showed that staff had completed training in key areas which included safeguarding and cardiopulmonary resuscitation. We also saw that staff had undertaken role specific training, for example reception and administrative staff had completed training on medical terminology, the role of the chaperone and refresher training on appointments and prescriptions. Training records for practice nurses showed that they had undertaken training relevant to their roles in the last year which included infection control updates, blood pressure updates and childhood immunisation. The practice also held regular educational afternoons which all staff were given the opportunity to attend. All new staff undertook an induction and we spoke with one recently appointed staff member who told us that the induction was very thorough and that they felt competent in their new role as a result.

All the staff we spoke with felt they had good access to training and that they were well supported in their roles. They told us that they usually had an annual appraisal, however for administrative and reception staff this had lapsed and they had not had an appraisal during the last year. Despite this staff said they felt very well supported in their roles and could always approach their manager for help and advice. We were told that annual appraisal would be reinstated for administrative and reception staff by the new practice manager who was starting in the next month. The practice nurses we spoke with told us that they had an annual appraisal with one of the GPs; however the practice was unable to locate the records for these.

Good

Are services effective?

(for example, treatment is effective)

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England). The practice was a training practice and each trainee doctor had a named supervisor who they met with on regular basis and who provided supervision for each surgery.

Working with colleagues and other services

There was evidence that the practice worked closely with other organisations and health care professionals. The GPs had monthly meetings with the locality health visitor to discuss children of concern. They also met weekly with the community matron and community nurses to discuss patients discharged form hospital and those identified as at risk of admission. The practice also had a monthly multidisciplinary meeting which included the GPs, practice nurses, community nurses, adult social care workers and primary care mental health workers to discuss patients with complex health and social care needs. The meetings also included representatives from the local hospice and a palliative care nurse so that the needs of patients on the terminally ill register could also be discussed. This helped ensure that people at the end of their life had a high standard of care.

Information sharing

The practice used electronic systems to communicate with other providers. Blood test and x-ray results, clinical letters from the local hospital including discharge summaries and reports from the Out of Hours providers were all received electronically. The practice had systems to provide staff with the information they needed. Staff used an electronic patient management system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a consent policy in place. All of the GPs we spoke with were aware of their responsibilities in relation to obtaining consent to care and treatment. All of the GPs we spoke with were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. We were provided with examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients' aged 40-75. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over. The practice provided a range of screening and preventative services such as a smoking cessation clinic, health awareness clinic and cervical screening and stroke monitoring. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing particularly for those patients for whom there was still time for lifestyle changes to be effective. For example, by offering opportunistic health checks during appointments to those identified with long term conditions. The practice's patient participation group ran several health awareness events during the year for the local community, for example on cancer and prostate, problems. There was a range of health promotion and prevention information available in the waiting area and on the practice's website. The practice also produced a monthly newsletter in conjunction with the PPG, which contained health promotion and prevention messages. For example information encouraging patients at risk to book their flu vaccinations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP survey and a survey of 469 patients undertaken by the practice in 2014. We also spoke with three patients on the day of the inspection. The evidence from all these sources showed patients were very satisfied with how they were treated. They told us that staff were very helpful, respectful and caring. Data from the national GP survey showed the practice scored above average in all areas. For example, the 93 per cent of respondents to the national GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. The proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern was 94 per cent. Results from the practice's own survey showed that 84 per cent of respondents rated the way they were treated by the receptionists as excellent or good.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room and that doors could be locked if necessary. We observed that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. All staff were discrete and were careful to follow the practice's confidentiality policy when discussing patients in order that confidential information was kept private. There was a system in place which allowed only one patient at a time to approach a partitioned area of the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

We observed that reception staff were polite and helpful to patients. Background music was played in the waiting areas to help obscure private conversations in the waiting areas and at the reception desk.

Care planning and involvement in decisions about care and treatment

The patient's feedback we received and the results of surveys showed that patients were positive about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, results from the national GP survey that 94 per cent of respondents stated that the last time they saw or spoke to a GP; the GP was good or very good at involving them in decisions about their care and 97 per cent of respondents stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care. All of the patients we spoke with told us that the GPs were very good at explaining things to them and the risks and benefits of treatment options.

Patient/carer support to cope emotionally with care and treatment

All the patient feedback we received showed that patients were positive about the emotional support provided by the practice and rated it well in this area. All the comments cards described the staff as understanding, caring and compassionate.

The practice made referrals to the primary care mental health service based on its premises that provided patients with access to psychological therapies. Staff were also able to signpost patients to a bereavement counselling service which was located near to the practice premises.

There was a wide range of patient literature available in the waiting area directing people to a number of support groups and organisations which included a wide range of information for carers. Training records showed that all staff had undertaken training on caring for the carer which helped them to identify carers and ensure they received the right support.

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 people's needs. The practice had a patient participation group (PPG) which met every month with the practice manager, a GP and practice nurse representatives. We met with three members of the PPG who told us that the practice really considered and listened to patient views and was responsive to their needs. We were provided with examples of how the practice had implemented improvements as a result of feedback from the PPG. For example, the PPG had input to the refurbishment of the practice which the GP partners had invested in themselves. This had involved a major expansion which provided additional facilities for patients. It included the installation of a lift to the first floor, new treatment and consulting rooms and more office space. The building was modernized and redecorated throughout. Carpet tiles in all patient areas with were replaced with vinyl flooring and lighting was replaced with brighter lights. The refurbishment included the building of an on-site pharmacy so patients had a more convenient service. The PPG told us that the refurbishment had resulted in a huge improvement to patient services and demonstrated the commitment of the partners to meeting patient needs.

The practice was able to demonstrate that it understood the needs of its registered population and had organised it services to meet these needs. An example of this was the work the practice had done to identify patients who may be a risk of suffering from dementia, particular those that may be overlooked in residential care. Through this work the practice was able to assess patients and support those with a dementia diagnosis. The practices diagnosis rate for dementia was three and a half times greater than the national average and significantly higher than southern England's average. The practice was able to support these patients with their health needs and help them make decisions about their future care and participate in end of life planning.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning and delivery of its services. The practice was situated in a three storey building with all of its services for patients situated on the ground and first floors. A lift to the first floor had been installed as part of the recent refurbishment. The surgery had facilities to accommodate wheelchairs and there was a disabled access toilet on the ground floor. The practice website could be translated into over 80 languages and staff were able to access translation services for patients whose first language was not English.

Access to the service

The practice was open from 8.30am until 6.00pm Monday to Friday. The practice offered both book on the day and pre-bookable appointments. Patients were able to book appointments up to four weeks in advance and individual GP surgeries ensured that most patients could have the choice of being seen on the day by their own GP. Patients were offered appointments with other GPs if their own GP was not available. Appointments could also be pre-booked, in or out of hours, via the practice's automated booking service. The practice had undertaken an analysis of patient demand to identify how many doctor sessions they needed a day so it could ensure there were enough staff to meet patients' needs.

By designating one single GP to undertake all home visits during the day, the practice had been able to extended appointment times for patients to 15 minutes. This gave patients more time and allowed GPs to undertake checks for long term conditions opportunistically. Also, as a result of being able to start home visits earlier in the day, inappropriate calls to the paramedics and hospital admissions had been avoided.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system was on display for the public to see on the notice board. Details of how to complain were also set out on the practice website and in the practice information leaflet.

We looked at the complaints record and responses to patients over the last twelve months. The practice had received six complaints during this period. There was evidence that complaints were responded to in a timely way and that they were resolved satisfactorily. There was evidence that the practice reviewed complaints. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a strong ethos for providing high quality care to patients and investing to improve its services but this was not documented in the form of a vision or strategy. However, its ethos was strongly evident in the investment of its own funds to refurbish the practice premises and build an on-site pharmacy to improve the quality of services provided to patients. All the staff we spoke with were able to articulate a shared ethos of providing the highest possible quality of care to patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on a shared computer drive. We looked at five of these policies. All five policies and procedures we looked at had been reviewed annually and were up to date.

The practice had named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding The staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. The practice had two GPs who it had designated to take the lead on QOF. These GPs were given protected time to review performance and actively identify where action was needed to ensure patients were receiving the best care and treatment. As a result, the practice met or exceeded all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease. In 2013/14 the practice achieved 99 per cent of the total QOF points available to it.

The practice had completed a number of clinical audits and there was evidence that the results of these were shared and discussed. Learning was implemented to improve outcomes for patients.

The practice held monthly meetings. Not all of the meetings had been recorded. The notes that we saw showed that the meeting usually included a discussion about significant events and the shared learning and action required. However, it was not evident that all aspects of performance, quality and risks were routinely discussed.

Leadership, openness and transparency

The practice did not have a documented leadership structure and although most staff felt supported by management there were times they weren't sure who to approach with issues.

Staff told us that they met regularly in their own teams and every three months as a whole practice. It was noted that not all meetings were minuted.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place to support staff which included equal opportunities, health and safety, discipline and grievance and personal harassment policies. These were included in staff handbook that was available electronically to all staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through its patient participation group (PPG), annual surveys and complaints. The practice ran a survey to look at the areas that the PPG had said were important to them. We looked at the practice's report on the last patient survey which provided an analysis of the results and identified areas for action. There was evidence that the practice had implemented actions as a result.

Staff told us they felt their views were valued and that they were involved in helping improve services and outcomes for patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and development. The practice held monthly development afternoons for clinical staff and every three months for all staff for education and learning. Staff we spoke with told us they always had an annual appraisal, however for

Are services well-led?

Good

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

administrative and reception staff this had lapsed and they had not had an appraisal during the last year. However despite this they told us they felt well supported in their roles and could always approach the manager for help and advice. A new practice manager had been appointed and once in post annual appraisals would be reinstated. The practice nurses we spoke with told us that they always had an annual appraisal with one of the GPs; however the practice was unable to locate the records for these.

All the staff we spoke with felt they had good access to training and that they were well supported in their roles.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had failed to ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate. This was in breach of regulation 21 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 19.- 3. (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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