Mansion House Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Mansion House Surgery 25 August 2015. Overall the practice is rated as requires improvement.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Some risks to patients and staff were not assessed and systems and processes were not fully implemented to keep patients safe. For example, there were no assurance systems in place to confirm cleanliness and infection control procedures were effective. Small patches of damp were evident in the building.
- Staff appraisals were not up to date for all staff groups
- Although some clinical audits had been carried out, we saw no evidence that audits were planned effectively or driving improvement in performance to improve patient outcomes.
- 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 on request and easy to understand; however this was not as readily accessible to patients as it could have been.
- Urgent appointments were usually available on the day they were requested; however patients said that they sometimes had to wait a long time for non-urgent appointments.
- The practice had a number of policies and procedures to govern activity and held regular scheduled meetings for all staff groups
- The practice had sought feedback from patients but did not have a patient participation group or website and was not included on the NHS Choices website.

Summary of findings

- The practice did not have a documented vision or business plan for the future; however they had identified some of the challenges faced. There was a leadership structure and staff felt supported by management. However, some of the systems and processes which should have been in place to keep patients and staff safe were not established.
- The practice had been instrumental in the development of a Community Nursing scheme to ensure more co-ordinated care in the community for older patients. Although this was a clinical commissioning group (CCG) incentive the practice had been proactive in developing and piloting the scheme.
- The practice had employed a care co-ordinator to support elderly, frail and palliative care patients
- The practice hosted an on-site ultrasound and 24 hour ECG facility for the clinical commissioning group.

We saw one area of outstanding practice:

- The practice had employed a care coordinator whose role was to ensure that appropriate care and support was in place for frail and elderly patients and those with dementia

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

Importantly the provider must:

- Ensure that all staff are given the opportunity to have a regular appraisal.

In addition the provider should:

- Review the process for identifying, carrying out and reviewing areas for clinical audit.
- Continue with their plans to set up a patient participation group and practice website.
- Develop a business plan to reflect and record aims, objectives, risk and mitigating actions.
- Put in place appropriate arrangements to maintain a clean environment and assess the risk, detect, prevent and control the spread of infections by carrying out regular infection control audits.

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 with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice manager team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There were enough appropriately trained staff on duty at all times to keep patients safe. Although the practice was clean and hygienic there was no evidence to confirm that formal infection control audits were carried out. Small patches of damp were also evident in the building and in particular near the inside of the door to the minor surgery treatment room. This could present an infection risk. The practice had a chaperone policy in place and staff called upon to act as a chaperone had received the appropriate training. All clinical staff as well as any staff who carried out chaperone duties had been checked with the Disclosure and Barring Service (DBS).

Are services effective?

Requires improvement

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

Nationally reported data showed patient outcomes for effectiveness were either above or in line with other practices in the local Clinical Commissioning Group (CCG) and England. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice was able to demonstrate post inspection that they had completed clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. However, it was clear that the practice did not have effective processes to help staff identify potential areas for clinical audits or record and review them. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and all staff had received training appropriate to their roles and responsibilities. Not all staff had received yearly appraisals which

Summary of findings

meant that there was no formal process in place to discuss personal and performance issues and identify training and development needs. The practice offered an in house ultrasound and 24 hour electrocardiogram (ECG) service.

Are services caring?

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were generally in line with or better than the national average. The majority of patients said they were treated well and were involved in making decisions about their care and treatment. The practice was proactive in identifying and supporting carers. The practice did not have a web site with links to health prevention and promotion information and there was a limited display of health prevention and promotion leaflets in reception both of which would enable patients to be supported in managing their own health and well-being. Neither was the practice included on the NHS Choices website. The practice did not have a patient participation group (PPG) at the time of our inspection.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were generally better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback about the practice was good and most stated they found it was easy to make an appointment with a GP within an acceptable timescale. The practice was taking steps to reduce emergency admissions to hospital for patients with complex healthcare conditions by ensuring these patients had fully comprehensive care plans. In addition the practice had been proactive in identifying the need for and establishing a Community Nursing Scheme and had also employed a care coordinator both of which had led to improvements in coordinated patient care. Systems were in place to ensure patients discharged from hospital were supported when appropriate. Although the practice was located in a listed building it had made improvements as far as possible to ensure the premises were well equipped to treat patients and meet their needs. Information about how to complain was available in the practice leaflet and more detailed complaint information was available on request; however this was not as accessible as it could have been. Evidence showed the practice responded quickly and appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led.

Summary of findings

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes which was reflected in the practice mission statement. However the practice did not have a formal business plan which identified future aims and objectives. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients by way of patient surveys, which it acted upon. Comprehensive induction guidance was available for staff. Regular structured staff meetings were held and there was an open and transparent culture across all staff groups within the practice.

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 patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 had a named GP and were routinely invited to attend an over 75 health check. The practice had been instrumental in identifying the need for and developing a Community Nursing Project with the local Clinical Commissioning Group (CCG) and had become a pilot for this project which had been running since November 2014. The aim of the project was to integrate services and deliver more coordinated patient care between community/district nurses, practice nurses and GPs to improve the service delivered to older patients, palliative care patients and those with long term conditions. This had led to numerous improvements including better end of life care, home visiting arrangements, medication reviews and care plans which the practice felt had led to a reduction in the number of patients admitted to hospital. The practice also employed a care co-ordinator whose role was to ensure that, with the consent of the patient or carer, appropriate care and support was in place for the frail and elderly and those experiencing dementia.

The practice actively identified and flagged palliative care patients to ensure they were supported appropriately and the palliative care nurse met with the clinical team on a weekly basis.

Home visits were routinely available and the community nursing team had developed a rolling programme to ensure reviews of long term conditions and annual assessments were carried out for housebound patients.

At 76.9% the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average of 73.2%.

People with long term conditions

Good

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

The practice was able to demonstrate comprehensive and regularly reviewed care planning for patients with long-term or complex conditions and had a system in place to ensure patients were recalled for reviews when required. Medication reviews were routinely timed to coincide with a patients long term condition review.

Summary of findings

GP leads had been identified for some of the more common long term conditions such as diabetes and respiratory problems and there was a dedicated chronic disease lead nurse. Chronic disease management clinics were held for patients with diabetes, respiratory problems, chronic obstructive pulmonary disease (COPD) and comorbidity. The practice worked with regard to the 'Walking Away from Diabetes' programme (a programme to reduce the likelihood of at risk patients developing type 2 diabetes) and encouraged diagnosed diabetics to self-manage their condition through DESMOND (diabetes education and self-management for ongoing and newly diagnosed diabetics) training.

The practice regularly reviewed and updated their protocols following the issue of new guidance from the National Institute for Health and Care Excellence (NICE) and ensured this information was cascaded to all clinical staff through weekly meetings.

The practice monitored how well it performed against key clinical performance indicators such as those contained within the Quality and Outcomes Framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). The practice had achieved 99.9% of the points available to them in respect of QOF for 2013/14 which was 5% above the local CCG and 6.4% above the national averages.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example looked after children or children subject of a child protection plan. Two of the GPs had been identified as the safeguarding lead and deputy. Bi-monthly multi agency meetings were held to discuss children at risk which were attended by the GP leads, midwife and health visitor.

The practice had a recall system in place for childhood immunisations and rates were above or broadly in line with local averages for all standard childhood immunisations.

Appointments were available outside of school hours commencing at 8.00am daily and up to 8.15pm one night per week. Cervical screening rates for women aged 25-64 were above the national average at 85.5% (national average 81.9%; CCG average 82.9%).

Summary of findings

The practice GPs carried out checks on newly born babies at 10 days old and used this as an opportunity to look for early signs of post natal depression or more serious mental health issues in the mothers.

Working age people (including those recently retired and students)

Good

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

Nationally reported data showed that 57% of the practice population either worked or was in full time education (national average 60.2%). In addition the practice had identified that only 17% of its patient population was aged 65 years or over. The practice was proactive in meeting the needs of these patients by offering online services such as being able to order repeat prescriptions, book appointments and view parts of their medical records. However, the practice did not have its own website so this service was hosted by an external provider. The practice was open until 6.30pm on a Monday to Friday and remained open until 8.15pm one night per week. Repeat prescriptions could be ordered at any time either online or by phone between 10am and 4pm on a Monday to Thursday and 10am to 3.30pm on a Friday. The practice was also involved in the Choose and Book scheme which enabled patients referred to a hospital or clinic to choose the provider of their choice and at date and time which is convenient. The practice was proactive in offering NHS health checks.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had a register of patients aged 18 or over with a learning disability and had developed a god working relationship with the local learning disability home. A recall system was in place to ensure these patients were offered an annual health check and were encouraged, with their carers if appropriate to participate in the development of their care plan. Since implementing the inclusion of carers in the process the practice had seen an improvement in this area. For example that dietary advice had been adhered to effectively.

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified a clinical lead for dealing with

vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role. Multi-disciplinary safeguarding meetings were held on a regular basis (bi-monthly).

The practice had identified a lead GP for drug and alcohol addiction. A drug counsellor from Unity Drug and Alcohol Recovery Service (who provide treatment and recovery support for patients and family members affected by substance misuse) attended the surgery on a fortnightly basis and joint clinics involving the lead GP and the councillor were held quarterly.

New mothers were routinely screened for post natal depression at their babies ten day check and their own six week check-up. Patients who had suffered bereavement were signposted to appropriate counselling services by the practice care co-ordinator. The practice was proactive in identifying carers and had developed an effective working relationship with the local carers association who had attended the surgery to deliver support and advice to patients.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (97% compared to an England average of 86%) and was in line with the England average for ensuring patients diagnosed with dementia had received a face-to-face review within the preceding 12 months.

The practice was committed to proactively and opportunistically offering assessment to patients at risk of dementia and depression and to continually improving the quality and effectiveness of care provided to this group of patients. The practice had employed a care co-ordinator whose role included identifying elderly patients who may be living with dementia and ensuring the appropriate care package was discussed and agreed with the named GP as well as the patient or carer before implementation. Patients were assessed using a recognised toolkit (the Outcomes Star) which focuses on re-enablement and maximising independence and well-being. Dementia screening was also carried out on patients over 65 as part of their NHS Health Check and during appropriate long term condition reviews. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the previous 12 months was 95% compared to a national average of 83.8% and CCG average of 84.8%.

Summary of findings

The practice had developed effective working relationships with the local crisis, community mental health services and local authority social worker teams and supported self-referral to the Cumbria Partnership 'First Step' programme (an initiative developed to provide free talking therapies for depression, anxiety and other mental health related issues).

Summary of findings

What people who use the service say

During the inspection we spoke with four patients and reviewed 40 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of patients were very happy with the care and treatment they received and felt they were treated with dignity and respect and received a service which met their needs.

Findings from the 2015 National GP Patient Survey published in July 2015 for the practice indicated most patients had a good level of satisfaction with the care and treatment they received. The results were generally in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. For example:

- 97% of respondents said the last GP they saw or spoke to was either very good or good at involving them in decisions about their care (local CCG average 85%). The same result for the nursing staff was 97% (local CCG average 88%).
- 95% of respondents said the last GP they saw or spoke to was either very good or good at treating them with care and concern (local CCG average 89%). The same result for the nursing staff was 98% (local CCG average 94%).
- 99% of respondents said the last GP they saw or spoke with was either very good or good at explaining tests and treatments (local CCG average 89%). The same result for nursing staff was 96% (local CCG average 93%).

These results were based on 106 surveys that were returned from a total of 302 that were sent out (response rate of 35.1%)

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff are given the opportunity to have a regular appraisal.

Action the service SHOULD take to improve

- Review the process for identifying, carrying out and reviewing areas for clinical audit.
- Continue with their plans to set up a patient participation group and practice website.
- Develop a business plan to reflect and record aims, objectives, risk and mitigating actions.
- Put in place appropriate arrangements to maintain a clean environment and assess the risk, detect, prevent and control the spread of infections by carrying out regular infection control audits.

Outstanding practice

The practice was able to demonstrate some areas of innovation that were felt to have a positive impact on its patient population. This included:

- The development and piloting of the Community nursing scheme to ensure more co-ordinated multi agency care for patients.
- The employment of a care co-ordinator to ensure appropriate care and support was in place for frail and elderly patients and those suffering from dementia

Mansion House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) Lead Inspector. The team included a GP and a specialist advisor with experience of practice management.

Background to Mansion House Surgery

The practice is based in the centre of Whitehaven and provides care and treatment to 6425 patients from the Whitehaven area. The practice is part of the Cumbria Clinical Commissioning Group and operates on a General Medical Services (GMS) contract.

The practice provides services from the following address, which we visited during this inspection:

Mansion House Surgery, 19/20 Irish Street, Whitehaven, Cumbria, CA28 7BU.

The practice is based in a listed restored Georgian mansion house. Disabled access is available at the rear of the property and the building provides fully accessible treatment and consultation rooms over three floors which are accessible by lift for patients with mobility needs. Although on-site parking is not available for patients, with the exception of one disabled car parking space, there is a pay and display car park near to the rear of the surgery.

The practice is open between 8.00am to 6.30pm on a Monday to Friday. On one night per week (either a Monday, Tuesday or Wednesday) the practice was open until 8.15pm.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Cumbria Health on Call (CHoC).

Mansion House Surgery offers a range of services and clinic appointments including chronic disease management clinics, family planning, maternity services, cervical screening, NHS health checks, immunisations, vaccinations, foreign travel advice and minor surgery. The practice consists of six GP partners (four male and two female), four practice nurses, two health care assistants, a practice manager, medicines manager, reception manager, assistant reception manager, finance administrator, care co-ordinator and eight administrative staff who provide reception, typing and secretarial services. The practice is a teaching practice and is involved in the training of GP registrars and foundation doctors (qualified doctors training to become a GP).

The Care Quality Commission (CQC) intelligent monitoring tool placed the area in which the practice is located in the fourth (out of ten) most deprived decile. In general people living in less deprived areas tend to have a lesser need for health services.

The practices age distribution profile showed higher percentages of patients in the 45 – 69 year old age groups than the national average. Average life expectancy for the male practice population was 79 (national average 79) and for the female population 82 (national average 83).

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

Detailed findings

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 August 2015. During our visit we spoke with a range of staff including GPs; the practice manager; practice nurses; healthcare assistants; medicines manager; reception manager; community nurse sister and members of the non-clinical staff team. We spoke to four patients in the surgery waiting room and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We also reviewed 40 Care Quality Commission (CQC) comment cards that had been completed by patients and looked at the records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

As part of planning our inspection we looked at a range of information available about the practice including information from the latest national GP Survey results published in July 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report accidents and near misses. Examples of improvements made as a result included:

- As a way of ensuring that patients were notified of the results of all tests they had undertaken the practice had introduced a dedicated test results line and a tick box pro forma. This pro forma detailed all of the tests requested which could be 'ticked off' as and when results were received.
- A patient who had mistakenly been invited into the surgery for an ECG (an electrocardiogram; a test that checks for problems with the electrical activity of the heart) rather than blood pressure monitoring had led to reviewing the system used for sending out invitation letters.

We reviewed a sample of significant event audit records and serious incident reports, and minutes of meetings where these were discussed. We were satisfied that the practice had managed these consistently over time and taken all necessary action to avoid possible recurrences.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded seven significant events/incidents during the 1 September 2014 to 31 August 2015 covering a wide range of issues. The practice was able to demonstrate the action taken to ensure these issues did not happen again. For example we were told of a significant event regarding the care of a palliative patient who wished to remain at home. Unfortunately the patient did not receive the care or support needed from the district nursing team to enable this and it was established that this had been due to a breakdown in communication between multi agency practitioners. As a result the practice had been proactive in developing and piloting the Community Nursing Scheme with the local CCG to address such problems. We saw evidence that information regarding such incidents was disseminated to staff by way of minuted practice meetings. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

National patient safety alerts were received by the practice manager and medicines manager. The medicines manager would carry out an audit using the practice computer system to search for patients who may be affected by the alert then disseminate the information to the appropriate clinicians. Safety alerts were then reviewed at weekly practice meetings

Overview of safety systems and processes

The practice had risk management systems in place for safeguarding, health and safety, medication management and staffing.

- The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and information about how to report safeguarding concerns and contact the relevant agencies was accessible by all staff. One of the GPs had been identified as the lead for safeguarding vulnerable children and adults and effective working relationships had been established with multi agency practitioners. For example, bi-monthly multi-disciplinary meetings were held involving the GP, practice nurses, health visitor, and midwife. Staff we interviewed stated they would feel confident in making a safeguarding referral if necessary and were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place

to highlight vulnerable patients on the practice's electronic patient records so staff were aware of any relevant issues when they rang to make or attend for appointments.

- A chaperone policy was in place and information about this was displayed in the practice waiting room. The nursing staff and health care assistants acted as chaperones and had received training on their roles and responsibilities as a chaperone (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All clinical staff had undergone a Disclosure and Barring Service (DBS) check.
- There were procedures in place for assessing, monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and the fire alarms were tested on a weekly basis. Regular fire evacuation drills were carried out, the last one being May 2015. All electrical equipment was checked to ensure the equipment was safe to use (last checked August 2015) and clinical equipment staff used to carry out diagnostic examinations, assessments and treatments, such as the defibrillator (a device used to restart the heart in an emergency), spirometer (a device that measures the volume of air inspired and expired by the lungs) and oxygen was regularly inspected and serviced.
- The premises were clean and hygienic throughout although there was evidence of a few damp patches. We were concerned that a patch of damp in the minor surgery room could present an infection risk; however we were told that this room was not used very often. A cleaning schedule was in place and the practice manager carried out a visual check of cleaning standards on a weekly basis. An infection control policy was also in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and cleaned every six months or more regularly if required. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms and were appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, hand soap, antimicrobial spray and wipes and hand towel dispensers to enable clinicians to follow good hand hygiene and infection control practice. The practice had an arrangement in place for the safe disposal and management of clinical waste. All waste bins were visibly clean and in good working order. A contact was in place with a company to carry out risk assessments and testing for legionella (a bacterium that can grow in water and can be potentially fatal) and we saw records to confirm this was being done with the latest check having been carried out on 22 August 2015. One of the GPs, a practice nurse and the practice manager had been designated as infection control leads and provided advice and guidance to colleagues as and when required. Staff had received infection control training. However, the practice was unable to provide us with evidence that any formal infection control audits had been carried out
- Effective arrangements were in place to ensure medicines requiring cold storage, such as vaccines, were stored appropriately. A policy was in place to ensure refrigerator temperatures were checked and recorded daily and cold chain audits were carried out to ensure that medication stored in the refrigerators was safe to use. The practice maintained a record of emergency drugs held on the premises. These drugs were stored appropriately with restricted access. During our inspection we found that a process was in place to check these drugs on a monthly basis to ensure they were in date, destroyed appropriately and re-ordered when required. Patients were able to re-order repeat prescriptions in a variety of ways including ordering at the practice, by telephone, online or by post. A duty system was in place and the duty administration officer dealt with any repeat prescriptions requested that day. This meant that all administration staff were aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in

line with best practice guidance issued by NHS Protect and medicines incidents and prescribing errors were recorded by the practice as significant events to ensure that similar incidents did not recur.

- The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included seeking proof of identification, evidence of a legal entitlement to work in the UK, references, qualifications, licence to practice if appropriate and Disclosure and Barring (DBS) checks. We also checked the General Medical (GMC) and Nursing and Midwifery Council's (NMC) records to confirm that all of the clinical staff were licensed to practice. DBS checks had been carried out for all clinical staff.
- The practice manager told us about the arrangements that were in place to ensure there were enough staff on duty at all times which included a policy dictating how many members of staff could be off at any time. Administrative and nursing staff were flexible in the hours worked during times of increased demand and would often work a split shift arrangement to ensure appropriate cover was in place. The GPs organised their leave so that only two GPs could be off together. The practice rarely used locum GPs but when this was necessary they tried to use ex-registrars who had previously worked at and knew the practice. Staff and patients we spoke to on the day of our inspection told us they felt there was enough staff to maintain the smooth running of the practice and to keep patients safe.
- Patients' records were kept on an electronic system which stored all relevant medical information. Older paper records were securely stored in a locked room. As well as flagging vulnerable children and adults the electronic system also flagged patients with dementia, mental health issues, learning difficulties and those who were carers or receiving palliative care which helped ensure risks to patients were clearly identified and reviewed.
- Staff were able to easily access the practice's policies and procedures. This helped to ensure that when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies and staff had received training in basic life support.

Emergency equipment was available including a defibrillator and oxygen. Emergency medicines held on site were in line with national guidelines, stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks and reciprocal arrangements were in place with neighbouring practices to provide accommodation and consultation rooms should the need be required. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The practice carried out a fire risk assessment on an annual basis and held weekly fire alarm tests. Fire extinguishers had been subject to an annual check and fire exits were clearly signposted.

Staff were able to tell us of the process they would follow if there was a medical emergency on site and had a 'collapsed patient' protocol. The member of staff alerted about the incident would activate an alarm on the practice computer system which would in turn alert one of the practice nurses, in the first instance, that their immediate attendance was required. Emergency bags and equipment were readily available. If the emergency had occurred in one of the waiting rooms patients were asked to move to the other waiting room and a screen was placed around the collapsed patient to protect their privacy.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health and Care Excellence (NICE) guidelines and had access to a number of clinical tools to aid with diagnosis and assessments. The practice was also in the process of adopting the use of the 'Map of Medicine', a clinical toolkit to support GPs with their decision making and referral quality. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Practice staff regularly attended training courses and sessions and learning would then be disseminated to colleagues through weekly clinical meetings. We saw some evidence of clinical audit on the day of our inspection and were forwarded examples of other clinical audits post inspection. It was clear, however, that the practice needed to improve its rationale for carrying out clinical audits as well as for reviewing results to monitor impact and effectiveness. The practice should also ensure clinical audits are centrally stored and easily accessible.

Chronic disease management clinics were held to cover a wide variety of diseases and comorbidity (the presence of two or more conditions or diseases). One of the GPs performed minor surgery on site approximately every six weeks and there was on-site access to ultrasound and 24-hour ECG facilities.

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including Gillick competency assessments of children and young people (Gillick competence is a term used in medical law to decide whether a child aged 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Although none of the staff other than one of the GPs had received training on the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Standards (DoLs) clinical staff were able to demonstrate an awareness of the principles and could give examples of best interest decision making in relation to Do Not Attempt CPR decisions.

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Protecting and improving patient health

A limited amount of health promotion and prevention leaflets were available in the practice waiting rooms. The practice did not have a website and therefore had no online links to health information or support services.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 at 85.4% was above the national average of 81.9%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was generally in line with or above local CCG averages. The main exception was for MMR Dose 2 which at 49% was lower than the local CCG average of 70.1%. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 57.1% (national average 52.3%) and the percentage of patients aged 65 or older who have received a seasonal flu vaccination was 77.9% compared to a national average of 73.2%.

The practice also offered NHS health checks for patients between the age of 40 and 74 as well as over 75 and new patient health checks.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Staff worked together and with other health and social care

Requires improvement

Are services effective?

(for example, treatment is effective)

services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that a variety of minuted multi-disciplinary team meetings took place on a regular and scheduled basis and that care plans were routinely reviewed and updated.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results showed the practice had achieved 99.9% of the total number of points available to them which was 5% above the local CCG average and 6.4% above the national average. This practice was not an outlier for any QOF (or other national) clinical targets. Data from the QOF results for 2013-14 showed:

- Performance for diabetes related indicators were better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- Performance for mental health related conditions were better than the national average
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was higher than the national average

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of six GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, fire safety, information governance, safeguarding, equality and diversity, infection prevention and control and more clinical based training for clinical staff. However only one member of staff had received training on the Mental Capacity Act (2005) and Deprivation of Liberty Standards (DoLS).

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurses reported they were supported in seeking and attending continual professional development and training courses.

The practice had previously ensured all staff undertook annual appraisals that identified learning needs. We were told by the practice manager however, that this process had slipped and appraisals were no longer held annually. The practice manager intended to address this issue but in the meantime was ensuring that staff had access to regular 1:1 supervision sessions where training needs could be discussed and identified. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses and gave staff protected time to undertake training.

We looked at staff cover arrangements and identified that there was always sufficient GP cover on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. The GPs, management team and reception staff covered for each other and the practice rarely relied on the use of locum GPs. Where this was necessary the practice tried to use ex registrars who had previously worked at the practice to ensure continuity of care. A registrars/locum induction pack was available.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments made by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 40 CQC comment cards completed 32 were positive. Words used to describe the practice and staff included outstanding, sympathetic, diligent, considerate, focused and life-saving. Negative comments received were in respect of delays in getting appointments, delay in being seen at the appointed time, manner of a locum GP and correspondence being sent to a relative in error.

Data from the latest National GP Patient Survey, published in July 2015, showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors. For example:

- 98% said the GP gave them enough time compared to the CCG average of 90% and England average of 87%
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and England average of 95%
- 95% said they felt they were treated with care and concern by the GP compared to the CCG average of 89% and England average of 85%
- 98% said they felt they were treated with care and concern by the nurse compared to the CCG average of 94% and England average of 90%

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times. National GP Patient Survey results showed that 94% of respondents found the receptionists at the practice helpful compared with the CCG average of 90% and England average of 87%.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A separate room was available if a patient wished to speak to a receptionist in private.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

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

The practice proactively identified carers and the practice computer system alerted staff if a patient was also a carer. Carers were signposted to relevant support services. The local carers association had attended the practice to provide support and advice.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results for practice GPs and nurses were generally above the national averages. For example:

- 99% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86.3%.
- 97% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%

Good

Are services caring?

- 96% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 93% and national average of 90%.
- 98% said the last nurse they saw was good at treating them with care and concern compared to the CCG average of 94% and national average of 90%

Staff told us that translation services were available for patients who did not have English as a first language and a notice was displayed in the reception area informing patents this service was available.

The practice was able to demonstrate that they analysed and responded to its patient survey results. However, the practice did not have a patient participation group (PPG) which would improve the practices ability to involve patients in decisions about the range and quality of services provided. We were told that this was an area the practice was hoping to develop in the near future.

Neither did the practice have a website or representation on the NHS Choices website. This meant that patients did not have online access to practice information or links to health information and support services or a means to providing online feedback. Online services such as booking appointments and requesting repeat prescriptions were hosted by an external provider. We were informed that the website was under development but that the practice were hoping to be able to utilise PPG members in the planning and creation of this once they had been appointed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to improve outcomes for patients in the area. For example the practice had been instrumental in developing and piloting a community nursing scheme which was helping to ensure that patients at risk of hospital admission had fully comprehensive care plans which were discussed and reviewed regularly.

The practice did not have a patient participation group although were trying to set one up in the near future. The practice could demonstrate that it did listen to and act upon the views of its patients by carrying out and responding to patient surveys. For example, in-patient surveys had identified that patients felt getting through to the practice by telephone was problematic. The practice had responded to this by ensuring that three separate telephone lines were manned during peak periods, introducing a dedicated test results line and on-line services.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice had extended opening up to 8.15pm one night per week for patients who could not attend during normal opening hours
- Home visits were available for patients unable to physically attend the surgery.
- Urgent access appointments were available.
- There were disabled facilities, hearing loop and translation services available. A member of the non-clerical staff team could use and understand sign language and had developed links with the local deaf association
- The practice offered over 75, new patient and NHS Health Checks.
- The practice had employed a care co-ordinator whose role included ensuring appropriate care and support was in place for the frail and elderly and those experiencing dementia
- The practice had been instrumental in setting up the Community Nursing Scheme in the locality

Access to the service

The practice was open between 8.00am and 6.30pm on a Monday to Friday and remained open until 8.15pm one night per week. In addition to pre-bookable appointments urgent and same day appointments were also available.

We looked at the practice's appointments system in real-time on the day of the inspection. The next routine appointment with a GP was not available until eight working days (12 calendar days) later. The practice manager told us that this delay was unusual and was due to one of the GPs being on maternity leave and another being due to go on imminent paternity leave. Urgent same-day appointments were made available for patients each day. Staff told us that the availability of appointments was constantly reviewed and the number of doctor sessions available would often be increased to cope with demand.

Results from the National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment was generally in line with or higher than local and national averages. For example:

- 90.3% of patients were satisfied with the practice's opening hours compared to the CCG average of 77.8% and national average of 75.7%.
- 80.9% of patients described their experience of making an appointment as good compared to the CCG average of 78.5% and national average of 73.8%.
- 67.4% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64.6% and national average of 65.2.

However, some results were lower than the CCG and national averages, such as:

- 72.2% of patients said they could get through easily to the surgery by phone compared to the CCG average of 80.3% and national average of 74.4%.
- 55% of patients felt they don't normally have to wait too long to be seen compared to the CCG average of 60.6% and national average of 57.8%

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. 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 including information in the practice leaflet. However, the practice did not display complaints information in reception and the majority of patients we spoke with were not aware of the process to follow if they wished to make a complaint. Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

The practice had received four complaints in the previous 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

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

All staff had been asked to contribute towards the development of a practice mission statement, which was 'To provide health care that is accessible, appropriate, safe and provided in a timely manner for the population to whom we provide a service'. Staff we spoke with showed they shared these values, and they consistently spoke about the care of patients being their main priority. The practice did not have a business plan and although there had clearly been discussions about risks possibly faced by the practice these and possible mitigating actions had not been recorded formally. For example, there were concerns that the practice may have to take patients from a nearby surgery which was considering halving its patient list size. This would have a huge impact on the practice at a time when demand to register with it was already high. At present the practice was currently accepting two new patients per week and a waiting list was in operation. Preference was being given to patients who were not already registered elsewhere in the area.

Governance arrangements

The practice had an overarching governance policy. This outlined the structures and procedures in place. Governance systems in the practice were underpinned by:

- A clear staffing structure and a staff awareness of their own roles and responsibilities.
- The implementation of comprehensive policies and procedures that all staff could readily access.
- A system of reporting and recording significant events and incidents without fear of recrimination and being able to demonstrate learning had been identified and acted upon
- Clear methods of communication including regular and structured meetings that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- Proactively gaining patients' feedback and engaging patients in the delivery of the service. Acting on any concerns raised by both patients and staff.
- The GPs were all supported to address their professional development needs for revalidation and all staff in appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints.
- Named members of staff took on lead roles. For example, there was a lead GP for areas such as safeguarding, infection control, medicines management and QOF.

Innovation

The practice was able to demonstrate some areas of innovation that were felt to have a positive impact on its patient population. This included:

- The development and piloting of the Community nursing scheme to ensure more co-ordinated multi agency care for patients.
- The employment of a care co-ordinator to ensure appropriate care and support was in place for frail and elderly patients and those suffering from dementia

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Regulation 18(a) The provider did not have in place suitable arrangements to ensure that staff employed within the practice were suitably supported in relation to their responsibilities as staff were not receiving regular opportunities for appraisal.