Dr Mazarelo & Partners (also known as Concord 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.

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Overall summary

Dr Mazarelo & Partners (also known as Concord Medical Practice) is situated in Washington and provides primary medical care services to patients living in and around the Washington area. The practice provides services to 5259 patients.

The service is registered with CQC to provide the regulated activities of; Diagnostic and screening procedures; Treatment of disease, disorder and injury; Surgical procedures and Maternity and midwifery services.

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 CQC at that time.

At this inspection we found there is a lack of clear leadership and vision within the practice. Governance arrangements are unclear. Although staff told us about actions they take to improve the service, there is a lack of a documented evidence to support this.

We found that practice is responsive in its approach to quality, rather than proactively planning for improvements.

Patients who use the service are kept safe and protected from avoidable harm, however the practice does not have a robust approach to investigations and there isn't a system in place which will enable the practice to identify trends in incidents, safety issues, performance issues, and to record learning. The provider is in breach of Regulation 10 Assessing and monitoring the quality of service provision.

The building is well-maintained and clean.

All the patients we spoke with are very positive about the care and treatment they receive. The CQC comment cards and results of patient surveys that show that patients are consistently pleased with the service they receive.

There is good collaborative working between the provider and other health and social care agencies which ensures patients receive the best outcomes. Clinical decisions follow best practice guidelines.

The practice regularly meets with the local CCG to discuss service performance and improvement issues.

The majority of patients registered with the practice are of working age. There are approximately 200 patients registered with the practice over the age of 65. Patients with long term conditions are reviewed at least once a year. The practice told us they have four patients registered with a learning disability and they all have a health action plan in place and annual reviews. The practice are aware of patients in vulnerable circumstances and actively ensure these patients receive regular reviews, including annual health checks. The practice maintains a register of patients who experience mental health problems and they have regular reviews. The needs of these population groups are identified by the practice and systems are in place to improve their access to care.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service required improvement with regard to safety. We saw evidence that significant events, incidents and complaints were investigated and reflected on by the staff; resulting in changes at the practice. However the practice did not have a robust approach to investigations and we saw evidence that not all causes of an incident were addressed. There wasn't a system in place which would enable the practice to identify trends in incidents, safety issues, performance issues, and to record learning. Staff were aware of safeguarding procedures, and when required made adult and child protection referrals. Effective systems were in place to oversee the maintenance of the building and keep staff, patients and visitors safe. The practice was clean. Medicines were stored and managed safely.

Are services effective?

The service was effective. Care and treatment was being considered in line with current published best practice. Patients' needs were consistently met and referrals to other services were made in a timely manner. The practice undertook clinical audit and monitored the performance of staff. Appropriate consent was sought when required.

Are services caring?

The service was caring. All the patients we spoke with during our inspection were very complimentary about the service. They told us that staff were kind and compassionate and they were treated with respect. Patients were involved in decisions about their care and treatment.

Are services responsive to people's needs?

The service was responsive to patient's needs. The practice conducted regular patient surveys into different aspects of the service and took action to make suggested improvements. Patients were able to have face to face or telephone consultations. Appointments and requests for repeat prescriptions could be made in person, by telephone or on line. There was a complaints policy and the practice responded to complaints appropriately.

Are services well-led?

Some aspects of the service were well led. The practice had a clear set of values which were understood by staff and these were evident on the practice website. Staff felt supported by the GP Partners and

Summary of findings

the practice manager. There were key staff who were identified leads for different areas in the practice however not all staff were clear who was responsible for specific areas. Clear systems were not in place for identifying and managing risks.	

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
The practice was knowledgeable about the number and health needs of older patients using the service. The practice actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. Medicine reviews were completed with all patients over the age of 75. The practice kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

People with long-term conditions
The practice was knowledgeable about the number and health needs of older patients using the service. The practice actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. Medicine reviews were completed with all patients over the age of 75. The practice kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

Mothers, babies, children and young people
The practice provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. All of the staff were very responsive to parents' concerns and ensured parents could readily bring children into the practice to be seen who appeared unwell. Staff knew what to do if they had a concern about child protection and a GP took the lead for safeguarding.

The working-age population and those recently retired
The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice had a comprehensive range of information which was available in the practice and on their website which covered the needs of their entire patient group. Staff had a

programme in place to make sure no patient missed their regular reviews for their condition, such as diabetes, respiratory and cardiovascular problems. Appointments were available prior to 9am and after 5pm Monday to Friday and on Saturday mornings.

People in vulnerable circumstances who may have poor access to primary care

The practice were aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a very good understanding of what services were run within their catchment area such as supported living services, care homes and families with carer responsibilities. Staff were knowledgeable and proactive when safeguarding vulnerable adults. They had access to the practice's policy and procedures and discussed vulnerable patients at the clinical meetings.

People experiencing poor mental health

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 51 patients which were very positive about the total experience they received from the practice. We spoke with 10 patients during the site visit and they told us that they had received excellent care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff involved them in the planning of their care and were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs.

We looked at the results of a patient survey conducted in March 2014 that collected the views of 100 patients who used the service. Patients were overwhelmingly very positive about the service they received.

We found that the practice valued the views of patients and saw that following feedback from surveys and the patient participation group, changes were made in the practice.

Areas for improvement

Action the service MUST take to improve

The practice did not have systems in place to regularly monitor the quality of the service being provided. Assessments of significant risks had not been undertaken. The practice must improve its approach to leadership and quality improvement. Also it must strengthen its approach to improve the quality and learning from risk management, audits and analysis of incidents and complaints. The provider is in breach of Regulation 10 Assessing and monitoring the quality of service provision.

Action the service SHOULD take to improve

There was no system for checking that healthcare professionals, such as doctors and nurses, were registered with the relevant professional bodies, i.e. General Medical Council and Nursing and Midwifery Council and therefore were still deemed fit to practice.

Dr Mazarelo & Partners (also known as Concord Medical Practice)

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC inspector and the team included a second CQC inspector, a GP and a practice manager.

Background to Dr Mazarelo & Partners (also known as Concord Medical Practice)

Dr Mazarelo & Partners is situated in Washington and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Washington area. The practice is providing services to 5259 patients of all ages. There is a higher percentage of the practice population in the 65 and over age group than the CCG and England average.

The practice is located in a single storey building and has a number of parking spaces on site, including disabled spaces near the main entrance. There are disabled toilets and baby changing facilities available.

The practice does not provide out of hours services for their patients and information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website. When the practice is closed patients access Northern Doctors Out of Hours Services.

The practice has three GP partners, one salaried GP, one nurse practitioner, one practice nurse and a practice manager.

The practice is open 8.30am to 6.00pm Monday to Friday and 9.00am to 11.45am on a Saturday. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nursing clinics.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- Is it safe?

Detailed findings

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 1 September 2014.

During our visit we spoke with seven staff including GPs, a nurse practitioner, practice nurse, the practice manager, two receptionists and a secretary. We spoke with 10 patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone.

We attended a listening event in Sunderland where representatives from voluntary organisations and members of the public shared their views about GP services. Prior to our inspection visit 51 patients completed CQC comment cards about their experiences of the service they had received and we spoke with 10 patients who attended for appointments during the inspection.

Are services safe?

Our findings

Safe Track Record

We saw there was an incident reporting policy in place which outlined why incidents should be reported, and how to report them, however there was no information about how they would be investigated or the mechanism for sharing any lessons learned. We spoke with staff and they were able to describe the incident reporting procedure and they discussed how action and learning plans were shared with all relevant staff. The practice had identified one of the GPs as the lead for incident reporting however not all staff were aware of who this was.

GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. We looked at the significant events that had been reported using the practice incident reporting system. We confirmed that staff were reporting incidents.

The practice did not complete a report of all the incidents that had occurred in the practice each year, for example how many medicine related incidents or administration errors were occurring. Without this the practice would not know if actions they had put in place to reduce the risk of incidents happening again were working.

We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents that were occurring.

Learning and improvement from safety incidents

We saw evidence that internal investigations were conducted when any incidents occurred and staff confirmed that investigations were undertaken and changes made to prevent them happening again. For example when the practice received a letter from the local hospital requesting a change to medicines following a patients' discharge, this did not get actioned. The practice implemented a system so the discharge letters were distributed evenly among the GPs ensuring they would be reviewed and patients received the care they needed following discharge from hospital.

However we found when looking at other investigations the practice did not have a robust approach to investigations that would identify all the causes and actions required to minimise the risk of it happening again. The outcome of another investigation into an incident involving a specimen was for, 'staff to take more care', there was no clear evidence of any change in practice. It did not identify why the incident had occurred and how they would minimise the risk of it happening again.

The GPs and nurses told us that if they were involved in an incident then they took part in the investigation and the lessons learned were disseminated at staff meetings. We looked at minutes of meetings but did not see evidence that key learning points had been shared with all the staff. If no clear system is in place to share learning then all staff would not be made aware of any changes to practice required. Staff we spoke with told us the practice encouraged staff to openly review the service and determine where they could improve.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or drugs, or give guidance on clinical practice. They told us the alerts came into the practice via e-mail and they were then distributed to GPs and nursing staff who checked to see if they were applicable to the practice and any action required was taken. Staff we spoke with confirmed they were made aware of relevant safety alerts. One of the nurses described a recent alert about blood sugar monitors and how they had identified any patients using them so they could get a replacement. We found no written record of actions taken in response to safety alerts about equipment and drugs was available.

Reliable safety systems and processes including safeguarding

The practice had 'child protection' and 'vulnerable adult' policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers. Staff had access to contact details for both child protection and adult safeguarding teams at the local authority. Staff were knowledgeable about the actions they needed to take if they suspected abuse and described how they would report and discuss issues with the GPs in the practice.

Most staff had received training in child and adult protection however not all the administration staff had completed safeguarding training. The GPs and nurses we spoke with were knowledgeable about the types of abuse, the signs they might see in an adult or child being abused and how to raise concerns.

Are services safe?

One of the GPs took the lead for safeguarding in the practice and had attended appropriate training to support them in carrying out their work, as recommended by professional colleges safeguarding guidance.

When safeguarding concerns were raised staff ensured these alerts were put onto the patient's electronic record. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health professionals such as health visitors, midwives and district nurses. We saw minutes of clinical meetings which were held every two weeks where vulnerable patients were discussed. This meant that people were protected from harm and children and vulnerable adults had the risk of abuse minimised.

There was a chaperone policy which clearly outlined when a chaperone may be required and which staff would undertake this role. We found that reception and administration staff who may be asked to chaperone had not had any training. Staff told us they were there to help the doctor, but were unsure as to how they could safeguard people. The chaperone role was therefore not effective in reducing the risk of abuse or protecting clinicians against false allegations. There was no information displayed informing patients that they could ask for a chaperone.

The practice was located in a health centre that was shared with other GP practices. The building was owned by NHS Property Services and they were responsible for the building maintenance, for example gas, electric and fire safety. We saw evidence that maintenance was undertaken as required. There was a process in place for staff to report any faults or problems and they confirmed that issues were dealt with in a timely manner.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. For example the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training.

We found the practice had emergency equipment and medicines available to be used in an emergency and records showed that the equipment and medicines were checked regularly. The emergency medicine box did not identify that adrenaline was stored in it. Staff therefore may not be aware that the medicine was available which could mean a delay in administration if it was required in an emergency. The provider had appropriate arrangements in place for dealing with foreseeable risks that could arise from time to time.

Medicines Management

We found that there were up to date medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were stored securely and only clinical staff had access. Medicines were checked regularly and stock rotated, this ensured that medicines did not go past their expiry date and remained safe to use. Room and fridge temperatures where medicines were stored were checked daily, however we found there were gaps when the temperature had not been documented. The medicine fridges had alarms to alert staff if the temperature was too low or too high. Processes were in place to assist staff in assuring medicines were stored in line with manufacturer's guidance.

Clear records were kept whenever any medicines were used. The records were checked by staff who reordered supplies as required. Any changes to the medicines held in the practice or carried in the doctors bags were discussed during clinical management meetings. Any changes were communicated to clinical staff in person and electronically. The equipment bags for doctors to take on home visits were regularly checked to ensure that the contents were intact and in date.

Cleanliness & Infection Control

During the inspection we spoke with the practice manager, nursing staff and reception staff about infection prevention and control (IPC) in the practice. The staff we spoke with were able to describe the measures they took to prevent the spread of infection. This included washing their hands before and after dealing with patients, regular washing and wiping down of equipment and work surfaces, and wearing personal protective equipment (PPE). Staff told us there was always sufficient PPE available for them to use, including masks, disposable gloves and aprons. We saw that hand wash, disposable towels and hand gel dispensers were also readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Clinical staff told us they had completed training in infection prevention and control.We looked

around the waiting area, the consultation and treatment rooms and found these were clean and tidy. The practice manager explained that domestic staff were employed by the local NHS Property Services Team and cleaned the practice at the end of each day. We saw that cleaning schedules were in place outlining which areas were cleaned daily, weekly and monthly, a copy of the schedule was available. Best practice guidelines for cleaning were being followed therefore reducing the risk of cross-infection. Monitoring visits were carried out by the property services team to ensure procedures were being followed and standards maintained. However the practice manager did not have copies of the monitoring reports so was unaware of any required improvements they may have identified. Feedback from patients said that the practice was clean. Patients were cared for in a clean environment.

Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff we spoke with told us that all equipment used for procedures such as smear tests and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Infection prevention and control procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. Not all staff were aware of who the IPC lead was. No IPC audits had been completed and the practice did not monitor the standards of cleaning provided by NHS Property Services, so any areas for improvement could not be identified and actioned. We spoke with the one of nurses who told us that they had received the immunisations required for working in a GP practice, this included Hepatitis B. We saw evidence that staff had their immunisation status checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance. We saw that a spillage kit was available for staff to use in the event of blood or body fluid spillages.

Legionella testing had been carried out at required intervals.

Staffing & Recruitment

We found that staffing levels and skill mix were monitored to ensure they continued to meet the needs of patients and staff. One of the nurses told us that they had recently completed nurse practitioner training so they could deliver an improved service for patients.

We discussed staffing levels and skill-mix with the practice manager and they explained when the different staff worked each week. This was reflective of the information on the practice website about the number and skill mix of GPs, nursing and administration staff. Patients we spoke with confirmed they could get an appointment to see a GP or nurse when they needed to. We found that the practice used the same GPs to provide locum cover as much as possible when they were required. This meant that the locums would be familiar with the practice and its' procedures.

The provider had a recruitment policy in place which outlined the process for appointing staff, and the pre-employment checks that should be completed for a successful applicant before they could start work in the practice. We looked at a sample of recruitment files for doctors, administrative staff and nurses, however as the staff in post had all been employed for a number of years their files did not reflect the current recruitment policy. We discussed this with the practice manager and they confirmed that all appropriate checks would be undertaken for any staff employed in the future.

There was no process in place to check that doctors and nurses were meeting the requirement to remain registered with their professional bodies, i.e the General Medical Council and therefore were still deemed fit to practice. This increased the risk of registration lapsing for those staff who should only provide care and treatment whilst registered with a professional body.

Dealing with Emergencies

There was a Business Continuity Plan in place for the health centre where the practice was located. This outlined how they would respond to emergencies and major incidents that might interrupt the smooth running of the service. The practice manager did not have a copy of this available on the day of the inspection however we saw a

copy after the inspection. This meant the practice had a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic events such as bad weather or illness.

Equipment

We were told that only trained staff operated the equipment used in the practice and staff we spoke with confirmed this. We looked at a sample of medical equipment throughout the practice and other electrical equipment and saw they had been serviced as required. We also found that fire extinguishers, alarm points and fire alarm systems were checked regularly.

We saw records showing that equipment had been serviced and maintained at required intervals by competent persons. These measures provided assurance that the risks from the use of equipment were being managed and people were protected from unsafe or unsuitable equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Current clinical guidelines and best practice were considered when patient care was delivered. We discussed with the practice manager, GPs and staff how National Institute of Health and Clinical Excellence (NICE) guidance was received into the practice. They told us that this was downloaded from the website and then disseminated to staff. They also said the computer system they used for patient records helped them adopt best practice guidelines, as the system incorporated NICE endorsed templates to guide diagnosis, care and treatment. It also provided in built guidance on prescription of medicines. This provided clinical staff with information from NICE on cost and effectiveness of drugs. Staff we spoke with all demonstrated knowledge of NICE guidance.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

Staff we spoke with told us they had access to the necessary equipment to treat and care for patients and were aware of how to use it.

We found that processes were in place to seek and record patients' consent and all decisions were made in line with relevant guidelines. Staff we spoke with were able to describe the consent process and demonstrated a good understanding of the Mental Capacity Act 2005 in relation to consent. Capacity assessments and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. The risks and benefits of treatment or procedures were explained to patients and they were made aware of alternatives where appropriate. Patients were giving informed consent where required.

Management, monitoring and improving outcomes for people

We found that the practice manager and provider had some mechanisms in place to monitor the performance of the practice and the clinicians' adherence with best practice. These included ensuring the team made use of clinical audit tools and performance data to identify where improvements were needed. For example the nurse practitioner explained how all the patients with respiratory conditions had been reviewed after data had shown that there was a high readmission rate to hospital for patients in their practice. During their review patients were assessed to ensure they were using their inhalers correctly and had enough emergency medication available if they started to feel unwell. The nurse had monitored readmission rates following the reviews and they had reduced.

The team was making use of clinical audits tools and staff meetings to assess their performance and outcomes for patients. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. For example, following an audit looking at the prescribing of anti-inflammatory medicines the GP carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with current guidelines.

The practice used the information they collected for the Quality Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided**.** The QOF report from 2012-2013 showed the practice was supporting patients well with conditions such as asthma, diabetes and heart failure.

Effective Staffing, equipment and facilities

We discussed training, supervision and appraisals for staff with the practice manager. They told us that all staff had undergone a range of training and received regular updates. We saw evidence that staff had completed mandatory training, for example basic life support and safeguarding, however not all staff were up to date with mandatory training. The practice manager told us that the Washington Locality Group (a group of local GP practices) had arranged a training programme in September which would enable staff to complete all mandatory training. We saw evidence that all staff were

Are services effective?

(for example, treatment is effective)

booked to attend. There was no training matrix in place which outlined what training each member of staff required, when they had attended, or were due to attend and when any refresher training was due. Without this the practice would not be able to monitor staff training.

We saw that staff had training in areas specific to their role for example, nurse prescribing and immunisations. The staff we spoke with confirmed that they had access to a range of training that would help them function in their role. The practice had protected learning time so this was used where possible for staff to receive training and updates relevant to their roles.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff told us that role specific induction, for example immunisation training for nurses would be available for new staff.

The patients we spoke with told us they were confident that staff knew what they doing and were trained to provide the care required. Staff received appropriate professional development which meant they had the skills and knowledge to care for patients attending the practice.

All the staff we spoke with confirmed they had received an appraisal and we saw copies of completed appraisal forms for staff. We found that the appraisals due in April 2014 had not taken place as the practice had been busy implementing a new computer system. The practice manager and staff confirmed they were scheduled for September. Staff told us it was an opportunity to discuss their performance, any training required and any concerns or issues they had. The nurses we spoke with told us that they did not have formal clinical supervision sessions, however they had protected time once a week to meet and discuss their practice, although no record was kept of this. All the staff we spoke with said they felt supported in their role and they felt confident in raising any issues with the practice manager or the GPs.

The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills. The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and updating of their skills. We spoke with the GPs about their revalidation with the General Medical Council (GMC) and they told us they had completed their revalidation. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

We found that staff were supported and received appropriate training and support to help them deliver care to patients attending the practice.

Working with other services

Staff told us that they met regularly with staff from the CCG, hospitals, palliative care and community services to discuss how general services and individual patients' needs would be met. We saw evidence that the practice staff worked closely with other professionals. Minutes from meetings confirmed that community nurses, health visitors, palliative care nurses and social workers attended to discuss treatment and care and ensure it was meeting the needs of patients.

Practice staff described how they worked with the community nursing and health visiting teams to ensure patients received appropriate and timely care.

There was a system in place to ensure the out of hours service had access to up-to-date information about patients who were receiving palliative care. This ensured that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

Counsellors from the mental health charity Mind used a room in the practice once a week to see patients. This enabled practice staff to liaise with them to ensure the needs of patients with mental health problems were met.

The practice had written guidance for dealing with abnormal test results. GPs and nurse practitioners were responsible for checking test results and adding any instructions for follow up. Staff would then phone patients to give additional instructions or request they attend the practice. Patients we spoke with confirmed they received their test results either by telephone or when they visited the practice. If patients had abnormal test results these were followed up appropriately.

We saw that when hospital discharge letters were received they were scanned into the patient's record and then a

Are services effective?

(for example, treatment is effective)

paper copy was placed in the 'Dr on call' box for things that had to be actioned that day. The doctor on call would review the letters and arrange for any follow up care to be arranged or for any prescriptions to be issued.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. We saw that this was promoted in the practice information leaflet and on the web site. The needs of new patients were assessed and a plan of the person's on-going needs to stay healthy was developed. We found that the staff proactively assessed patients to identify any potential problems that may develop. For example patients over the age of 45 were offered health assessments which would support the early identification of health problems such as diabetes.

We saw the practice took steps to identify which patients attending the practice had a caring role and there was information about carers support groups available in the waiting area for patients.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff were familiar with the steps they needed to take to protect patient's dignity. Consultations took place in purpose designed consultation rooms with an appropriate couch for examinations and curtains to protect privacy and dignity. We saw the provider had confidentiality and chaperone policies in place and the staff we spoke with were aware of these. We found that administration staff who were asked to perform chaperone duties had not received any training therefore may not be aware of their role and responsibilities when supporting patients. There was no information displayed in the practice explaining that patients could ask for a chaperone during examinations if they wanted one.

Patients we spoke with and feedback on the CQC comment cards was very positive and confirmed that the staff and doctors effectively protected patients' privacy and dignity. Staff were always polite and respectful and treated them with compassion and understanding.

Reception staff treated patients with respect and ensured conversations were conducted in a confidential manner. We observed receptionists being extremely tactful when triaging requests. Phone calls from patients were taken by administration staff in an area where confidentiality could be maintained. There was a room available if patients wished to discuss a matter with the reception desk staff in private, however there was no notice informing patients that this was available.

Information was available to signpost people to support services. This included MIND for help with mental health issues, the Macmillan service for support following bereavement and carers support groups. We found that the practice sent a card to families of patients who had died to express their sympathy and offer support. The card also included information about how they could access bereavement support.

Feedback from patients expressed their satisfaction with the approaches adopted by staff and they felt clinicians were extremely empathetic and compassionate and they told us care was personalised, and enabled them to maximise their health and well-being and enable a good quality of life.

Involvement in decisions and consent

Patients we spoke with told us that they had been involved in the decision making about their care and felt supported by the team. One patient told us they felt that they were able to talk to the doctor as equals, even to the point where recently they had been able to negotiate changes to their medication. Patients were able to consider different options for their treatment, discuss them with staff and were involved in decisions about their care.

We saw that access to interpreting services was available and information could be obtained in other languages and formats when necessary. This meant that all patients could be involved in decisions about their care, for example when English was not their first language.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

We found that the practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties and there was also a toilet for disabled patients. Patients who had appointments could use an electronic touch screen monitor in the waiting room to confirm their arrival, or speak with the staff at the reception desk. There was a large waiting area with plenty of space for wheelchair users.

Patients who used the service played a role in identifying where improvements could be made. For example we were told by representatives from the Patient Participation Group (PPG) that 18 months ago they had said they were not happy that there wasn't a female doctor in the team. Since then a female doctor had been employed. The practice now had male and female GPs which meant patients could choose to see a male or female doctor.

We saw that access to interpreting services was available and information could be obtained in other languages and formats when necessary. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. All patients could be involved in decisions about their care, for example when English was not their first language.

We found that the practice was responding positively to the needs of their patients.

Access to the service

We found that patients could make their appointments in different ways, either by telephone, face to face or online, via the practice website. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. Patients could request a text reminder to be sent the day before their appointment. This assisted in reducing the number of patients who did not attend appointments.

The practice was open until 6.00pm Monday to Friday and also offered extended opening hours on Saturday mornings. The practice also provided telephone consultation appointments. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse. Results from the patient survey indicated that awareness of the telephone consultations was not high. We saw that the practice had taken action to improve awareness with information displayed in the waiting area and on the practice website.

Patients we spoke with, feedback from CQC comment cards and the patient survey confirmed they were able to get appointments when they needed them, this included same day appointments.

We also found that patients could order repeat prescriptions via their local pharmacy, in person or on line. This meant the practice was using different methods to enable patient's choice and ensure accessibility for the different groups of patients the practice served.

We saw information displayed in the waiting area and on the practice web site about what to do in an emergency, in hours and out of hours.

Meeting people's needs

We saw that there was a process in place for choose and book referrals to other services. The secretary explained that the choice discussion took place during the consultation and then the patient was asked to see her and an appointment was booked before the patient left the practice. We observed a patient come out of the GP's room and see the secretary who took them through the booking system and arranged an appointment before they left the practice. Referrals to hospital and other services were done in a timely manner and any investigations required, for example x-rays were arranged. Patients confirmed they had had no problems when they had been referred to other services.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to make a complaint was on the practice website but was not displayed in the waiting room. We saw that the complaints procedure had details of who patients should contact and the timescales they would receive a response by.

Patients we spoke with told us they were not aware of the complaints procedure but if they were not happy with something they would raise it with a member of staff. Staff

Are services responsive to people's needs?

(for example, to feedback?)

we spoke with told us they were aware of the practice complaints policy and procedure and described how they would support someone who was not happy with the service. We found patients could be supported to make a comment or complaint if they were not satisfied with the service.

The practice had received two complaints in the past 12 months. We saw that where possible they had investigated and resolved, to the satisfaction of the complainant. They also recorded the actions agreed to prevent a similar issue occurring in the future.

The provider had established a patient participation group (PPG).

Are services well-led?

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

Our findings

Leadership and Culture

The practice had a clear vision which was understood by staff and was evident on the practice website. The practice's aim was to deliver the best care and focus on continually improving the health of their patients.

We spoke with two GPs and one told us there was no strategy for the future other than maintaining the quality of the service. They identified the risks to the service as retaining quality staff, ensuring competent staff and identifying gaps in clinical knowledge. However there was no documented plan about how those risks were going to be managed.

Governance arrangements

The practice had identified leads for key areas such as clinical audit, infection prevention and control (IPC) and safeguarding. However from discussions with staff it was clear not all staff were aware of who the leads were, for example not all staff knew who the lead was for IPC or safeguarding.

From our discussions with staff we found that they looked to continuously improve the service being offered. We saw evidence that they used data from various sources, incidents, complaints and audit to identify areas where improvements could be made.

The staff we spoke with told us there was an open culture in the practice and they could report any incidents or concerns about practice. This ensured honesty and transparency was at a high level and challenges to poor practice between all staff was the norm.

Systems to monitor and improve quality and improvement

The practice did not have in place a planned programme for monitoring all aspects of the service provided. We saw that a number staff had undertaken audits relating to their individual areas of practice and there was evidence that improvement had taken place as a result. However these audits had not been practice wide and therefore it was not possible for any learning to be implemented by all staff. There was no planned programme of audits to be completed so in some instances the audit cycle had not been completed. We also found that action plans were not developed following all the audits so it was unclear who was responsible for actions, dates for completion and if they had been completed.

We found there were no systems in place to analyse incidents, significant events or complaints over a period of time to enable the practice to identify trends in incidents and performance issues and to record learning.

We found that no risk assessments had been undertaken of significant risks to reduce the potential harm to staff, patients and visitors.

The practice regularly submitted governance and performance data to the CCG. We saw evidence that the GPs, practice manager and nurses attended CCG meetings where performance and quality were discussed. The practice manager told us that the practice then looked at how they could improve things in the practice, such as reducing the number of admissions to hospital for patients with respiratory problems. There was no evidence that a co-ordinated approach was taken to address performance issues in the practice.

Patient experience and involvement

The practice had established a Patient Participation Group and we saw that the practice encouraged new members to join, particularly from younger patients. Posters were displayed in the waiting areas and there was information on the practice website encouraging patients to become involved in the PPG. We found that the practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice also carried out patient surveys and we saw an action plan had been developed following the March 2014 survey. Patients were also encouraged to provide feedback through the practice website. We found that the practice was very open to feedback from patients.

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

We spoke with three members of the PPG group and they told us they had been asked if they would like to make any changes to the annual patient questionnaire, which they had done by changing one or two words to make it easier to understand. They also said that the group had taken responsibility for dealing with the estates department to get the taps changed in the male patient toilet. They told us the group felt really valued in being asked to contribute

Are services well-led?

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

to improvements in the practice. They saw the PPG as an opportunity to engage in two-way discussion with the practice, and a way of being kept informed about changes that were coming up.

We did not see any evidence that staff surveys were undertaken but staff told us they could raise any issues at team meetings or with the GPs and practice manager. There was no whistle blowing policy in place to inform staff of how they could raise concerns within the practice and externally.

Management lead through learning & improvement

We saw that all the doctors and relevant staff were able to attend a 'protected learning time' session on one afternoon each month. Meetings included the GPs and nurses and also members of the external multi-disciplinary team such as district nurses and health visitors.

Staff we spoke with could detail how they had improved the service following learning from incidents, complaints and audits and told us that these were discussed at staff meetings so actions and lessons learned could be shared with all relevant staff. We reviewed minutes from two clinical meetings and found no evidence that these areas were discussed. Also, we found no evidence of how any lessons were shared with the non clinical staff.

Identification and management of risk

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents. Although staff had been identified as leads for specific areas there were no clear systems in place for monitoring their areas such as whether infection control policies and procedures were being followed.

We found that one of the nurses had been supported to complete their nurse practitioner training after it was identified that this would improve the service for patients. They were now able to see and treat patients with minor illnesses which eliminated these patients' need to see a doctor.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a register of all patients over 75. A named GP was accountable for the care of each patient and individual care plans were being developed to ensure patients' needs were met and unplanned admissions could be avoided. Flu and shingles vaccination programmes were in place in the practice. There was a carers register so staff were able to provide support to older patients if they were a carer.

There was a booklet and newsletter available for older people which gave advice on various issues which included help with heating costs.

Each patient over 75 was invited to attend the practice at least once annually for an assessment. Multi-Disciplinary Team (MDT) meetings were held to discuss older people who were struggling. The GPs and nurses ensured patients and carers received appropriate coordinated, multi-disciplinary support.

Unplanned admissions and readmissions for this group were regularly reviewed and action was taken to make any necessary improvements.

We found staff had the knowledge, skills and competence to respond to the needs of this population group.

Access to services, including flexible appointment times and same day telephone consultations, where appropriate were available.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The nurses held regular chronic disease management clinics to review and monitor patients with long term conditions and give relevant support where needed. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their conditions. There was care planning in place for those patients whose long term conditions were most at risk of deteriorating and whose conditions were less well controlled.

Where patients did not attend a review appointment for their long term conditions, the practice would contact them three times to arrange further appointments to give patients the opportunity to attend an appointment.

The IT system used by the practice allowed staff to identify if a patient had multiple long term conditions. This meant all such conditions could be reviewed at the same time, rather than needing a separate appointment for each one. Patients with a long term condition were identified and a code was put onto their electronic patient record. This assisted the practice with maintaining up to date disease registers and in recalling patients for their health reviews.

The practice worked with services based in the community to support patients to receive the care they required. For example, there were regular meetings with district nurses and social workers to discuss the care of the patients with long term conditions. They practice also worked closely with the '24/7' community nursing team. They were able to offer more intensive treatment and care, which would assist in reducing the need for patients to go into hospital. They practice and patients could contact the service directly and one patient told us they had used the service the previous weekend.

The practice reported that there was good access to secondary health services, such as a diabetes specialist nurse, podiatry and a respiratory nurse specialist. The nurses told us that they could refer patients directly to these services so patients' treatment would not be delayed.

The practice was identified as having high admission rates to hospital for patients with respiratory disease so all the patients had been invited for a review. During their review patients were assessed to ensure they were using their inhalers correctly and had enough emergency medication available if they started to feel unwell. The nurse had monitored readmission rates following the reviews and they had reduced.

Staff told us for those patients who need urgent medical advice, four to six appointments were kept open every day to request. If these urgent appointments had been filled, staff told us the doctor would endeavour to see patients at the end of the morning or afternoon surgeries.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

There were arrangements in place to identify children and young patients who were being abused or were at risk of being abused and ensure that appropriate action was taken. Although staff demonstrated that they had an understanding of the indicators of abuse and would take action if abuse was suspected, some staff were unclear about whether the practices had its own policies and procedures and the formal procedures to follow if abuse was suspected. Staff had access to contact details for child protection teams.

Midwifery services were not provided at the practice but any female patient who became pregnant would be referred to book in with the midwife who was located in the same health centre.

There were regular baby clinics held in the practice to give parents and their young children access to a vaccine service and advice as necessary. Six week baby checks were carried out and health and development checks were undertaken as appropriate. If children did not attend for appointments then the staff followed this up with the health visitor. Women were offered six week post-natal health checks to ensure their health and wellbeing after giving birth.

We found that the practice responded to the needs of parents, babies, children and young people. The appointments system meant that they were able to attend the practice at a time that suited them. Appointments were available outside school hours.

The practice offered access to advice and support with sexual health for young people. We also found information was available about a 'Young people's project' which was aimed at identifying children and young people who may have a caring role so that they could access support.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

We found that the practice responded to the needs of working age patients. The appointments system meant that they were able to attend the practice at a time that suited them. Appointments were available after 5pm and on Saturday mornings. Telephone appointments were also available for those who would find it difficult to attend an appointment in the surgery due to work commitments.

The practice gave patients choice when referring to secondary care. This included choosing a hospital or healthcare location which was most convenient for them. This could be near to where they work.

We found the practice had information and advice to patients about general health conditions.

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

The practice offered smoking cessation sessions. All patients over 40 who attended the practice had their blood pressure checked so any problems could be identified before the any possible symptoms developed.

There was information available to support patients who planned to travel to help plan the healthcare they would need to keep them safe, such as travel vaccinations. There was information available for patients who had recently retired, such as from Age UK and a pack from the NHS local area team. This gave patients advice on health and social issues such as how to access assistance with fuel costs.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The GPs and nurses told us that access to GP services was offered to any patients in vulnerable circumstances, who requested it at the practice. This included those patients who identified themselves as homeless. All patients were treated in the same way and were given advice to ensure they could access appropriate healthcare and treatment. This included check-up at registration, breast screening, cytology and advice about the impact of social factors on health, such as smoking and use of alcohol.

The practice held a monthly multi-disciplinary team meeting where vulnerable patients were discussed and any actions and support required was agreed. For example we saw that a joint visit had been undertaken by the GP and social worker for a vulnerable patient in their own home.

The practice had a register of patients who had learning disabilities and the GPs and nurses told us that health action plans had been developed for these patients and they all had an annual review.

We found that the practice had considered the needs of those people with physical disabilities who might have problems in accessing the building.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

A counsellor from the mental health organisation, Mind, used a consultation room in the practice to enable them to see patients closer to home. The GP told us they could refer patients to this service. We saw there was information available about this service within the GP surgery.

The practice had a register of patients who had poor mental health. For those patients with enduring poor mental health the practice put in place care plans to determine how they would support patients to achieve improved mental health.

The practice told us that they had access to services provided by the local crisis team if a patient presented at the surgery with a mental health crisis.

This section is primarily information for the provider

Compliance 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.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have effective systems in place to effectively assess and monitor the quality of the service provided and the processes to identify assess and manage risks were not effective. Complaints and incidents were not always fully investigated. Staff were not always aware of who the leads were for specific areas and leadership roles and responsibilities were not clear. Regulation 10 (1)(a)(b), (2)(b)ii (c)i