City Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at City Road Medical Centre on 23 February 2016 and 25 May 2016. Overall the practice is rated as good.

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

- There was an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and managed. However, risk assessment related to the availability of medical oxygen in the practice needed to be updated and formalised.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice operated walk-in clinics most mornings and patients said they found it easy to see their GP. There was one regular GP which allowed for continuity of care, with urgent appointments available the same day.
- The practice did not have a nurse and the GP carried out cervical cytology. This was explored with patients when they first joined the practice in view to organising an alternative arrangement.
- All staff were longstanding including the practice manager. However, some governance processes needed strengthening to ensure appropriate risks were identified and minimised in the absence of the practice manager.

The areas where the provider must make improvement are:

Summary of findings

- Risk assessments must be robust to support decision not to carry out a DBS check for clinical staff.

The areas where the provider should make improvement are:

- Ensure a formal risk assessment is in place on regards to availability of medical oxygen in the practice.
- Ensure audit standards are set with completed cycles.
- All policies should be reviewed regularly and minutes of meetings should be formally recorded.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. The practice had systems in place to keep people safeguarded from abuse. Staff demonstrated they understood their responsibilities and how to respond to a safeguarding concern. Risks to patients were assessed and the practice sought advice from experts where appropriate. Some staff members worked as Healthcare assistant (HCAs) and acted as chaperones. However, Disclosure and Barring Service (DBS) check had not been undertaken for them. A risk assessment was in place but this was not appropriate as it only stated that they could not be left alone with children and did not address vulnerable adults and all the roles these staff would be performing.

Are services effective?

Good

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the local and national average for most indicators. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits were carried out but some were data searches without completed cycles. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

Data from the national GP patient survey showed patients rated the practice slightly (but not significantly) below others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. The practice staff were able to speak some of the languages spoken by patients and could explain to patients where appropriate. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice was taking part in

Summary of findings

the Primary Care Commissioning Framework (PCCF), a CCG initiative to help deliver improvements in clinical outcomes for patients. The practice operated a walk in clinic in the mornings most days and patients said they found it easy to get an appointment. There was continuity of care as there was one GP who in the absence of a practice nurse carried out long term reviews. However, if patients wished to see a female clinician, alternative arrangements were explored with patients when they joined the practice. There was evidence that the practice had arrangements to monitor and improve quality and identify risk. However, some risks such keeping medical oxygen in the practice needed to be formalised.

Are services well-led?

Good

The practice had a strategy to deliver high quality care and promote good outcomes for patients. The management team consisted of the GP provider and the non-clinical partner along with the practice manager. All of the staff were long standing and felt supported by management. The practice had a number of policies and procedures to govern activity.

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 offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had carried out reviews of patients over the age of 75 years who were taking eight or more medicines.

People with long term conditions

Good

In the absence of a practice nurse the GP managed patients with long term conditions and the practice achievement for the quality and outcomes framework (QOF) was higher than local and national averages. Patients at risk of hospital admission were identified as a priority. We were told that unplanned admission rate for the practice was the second lowest within the CCG despite being located near a hospital. Data we looked at showed that the practice unplanned admission rate was lower than those compared locally. Longer appointments and home visits were available when needed. All patients diagnosed with a long term condition had a named GP and a structured annual review to check that their health and medicine needs were being met. For those patients with the most complex needs, the clinicians worked to meet their needs working with other relevant health care professionals where appropriate.

Families, children and young people

Good

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Staff had access to safeguarding folders in the reception with contact details for the relevant safeguarding team. Same day appointments were available for children and appointments were available outside of school hours with extended opening hours on Mondays. We saw positive examples of joint working with midwives and health visitors. The practice did not employ a nurse and the GP (male) carried out cervical cytology screening. The provider told us that this was explored with patients when they first joined the practice in view to making alternative arrangements.

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Working age people (including those recently retired and students)

Good

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice operated a walk in system for morning appointments from Mondays to Thursdays and patients we spoke with were positive in regards to this. The practice offered online services and telephone consultations as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice held a register of patients living in vulnerable circumstances including those experiencing poor mental health and those that had a learning disability. The practice offered longer appointments for patients with a learning disability. The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Information was made available at the practice to sign post patients to various support groups and services. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results were mixed when compared with local and national averages. Of the 389 survey forms that were distributed, 69 were returned. This represented an 18% completion rate.

- 92% of patients found it easy to get through to this practice by phone compared to the local CCG average of 62% and the national average of 73%.
- 67% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local CCG average of 76% and the national average of 85%.
- 83% of patients described the overall experience of this GP practice as good compared to the local CCG average of 76% and the national average of 85%.
- 53% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards which were all positive about the standard of care received. Patients stated that staff were friendly, helpful and treated them with dignity and respect.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. They told us that they could get an appointment when they needed most of the time and had received home visits and telephone consultations from the GP when needed.

Areas for improvement

Action the service MUST take to improve

- Risk assessments must be robust to support decision not to carry out a DBS check for clinical staff.

Action the service SHOULD take to improve

- Ensure a formal risk assessment is in place on regards to availability of medical oxygen in the practice.
- Ensure audit standards are set with completed cycles.
- All policies should be reviewed regularly and minutes of meetings should be formally recorded.

City Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

On our first inspection the team was led by a CQC Lead Inspector which also included a GP specialist adviser. On our second inspection visit, the team consisted of the CQC lead inspector

Background to City Road Medical Centre

City Road Medical Centre provides primary medical services to approximately 1900 patients in the local community. The practice is a partnership between one GP (male) and one non clinical partner. The practice is located on City Road, Edgbaston, Birmingham. The practice did not have a nurse and the GP carried out many of the roles of the nurse. Three of the reception staff members were trained as Healthcare Assistants (HCAs). The non-clinical team consists of a practice manager, the non-clinical partner who was also the registered manager and assisted the practice manager in the day to day running of the practice. There was also a team of reception staff.

We inspected the practice on 23 February 2016. At that inspection the GP partner and the practice manager were on leave and a locum GP was covering. We agreed with the GP partner that we would follow up on any issues when they returned. When the GP had returned we arranged to follow up on the findings on 25 May 2016. On this inspection we spoke with the provider GP and the non-clinical partner and the practice manager.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some directed enhanced services such as, childhood vaccination and immunisation schemes. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice opening times are 9am to 6.30pm Mondays to Thursdays and operates a walk in clinic in the mornings. On Fridays the practice opens at 9am and closes at 1pm. When the service is not open between its core hours of 8am to 6.30pm, an alternative service is available contracted by the practice. On Mondays the practice provides an extended hours service until 7.30pm. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by 'an external out of hours service provider. There were notices to inform patients of this arrangement in the surgery as well as through the practice website.

The practice is part of NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in one of the most deprived areas. The practice has a higher than the national average number of patients aged between 20-40 years. The practice also had lower than average patients aged 50 years and over.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 February 2016 and 25 May 2016.

During our visit we spoke with a range of staff including the GP partner, the practice manager, the non-clinical partner and administration staff. We also spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff members we spoke with were aware of the process for reporting and escalating incidents. The practice used an electronic system to report incidents which was shared with the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. A staff member we spoke with told us that they had discussed the incident reporting process and the use of the electronic system in staff meetings.

We saw that the practice had recorded two significant events in December 2015 that was related to the diagnosis of cancer. The practice also recorded three other incidents in the last three months. We saw that one of the incidents related to management of a patient with a specific illness. As the incident was shared with the CCG, we saw the local hospital had provided the practice with a management pathway for patients with this condition.

The practice received patient safety alerts. Records of relevant alerts were kept to confirm relevant staff members had acknowledge they had read the alert and had taken action where appropriate.

Overview of safety systems and processes

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff in hard copy as well as electronically on the practices computer system. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP was the safeguarding lead for both children and adults at the practice and staff members we spoke with told us that they would always refer to them if there were any issues.

The GP and all staff had received training in safeguarding appropriate to their roles. There was contact details for other relevant agencies should staff require further advice. This included details of the domestic violence team. Staff members we spoke with demonstrated that they understood their responsibilities. For example, one staff member we spoke with told us that they had contact details for the safeguarding teams at Sandwell and Birmingham local authority. This was because patients registered at the practice were from both local authority areas. They also told us that they would give out keyrings and pens with contact details of the domestic violence team where appropriate.

Notices were in place advising patients that chaperones were available if required. Staff members we spoke with were aware of the role and purpose of a chaperone. The healthcare assistants (HCAs) carried out the role of a chaperone but had not undergone a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We saw that risk assessments had been carried out by the practice. However this was not robust. The risk assessments identified that staff members were never alone with a child, however did not include risks that may relate to vulnerable adults.

The practice had a DBS check policy which stated that staff employed after 31 December 2012 would be subject to a DBS check. However, no staff members had been recruited after the date and the policy did not address existing staff. The risks associated with not having DBS checks for staff had not been appropriately considered.

There were arrangements in place for managing medicines, including emergency medicines and vaccines, in the practice intended to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines.

The practice carried out regular medicines reviews with input from the medicines management team from the CCG.

Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Computer based prescription forms were kept in the surgeries with the rooms being locked when not in use.

The practice did not have a nurse and the GP carried out many of the roles of the nurse. Some staff members were trained as Healthcare Assistants (HCAs) who only

administered the pneumococcal and flu vaccine. There were Patient Specific Directions (PSDs) in place for these. The GP told us that they supervised the HCAs and at times administered the vaccine themselves.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. We saw evidence that a fire risk assessment had been carried out in May 2015 and a fire drill was carried out in June 2015. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Other risk assessments to ensure safety such as control of substances hazardous to health (COSHH) were not available on the day of the inspection. The practice manager was away and the assistant practice manager was unable to locate them on the day. However, this was forwarded to us following the inspection.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents. There was a business continuity plan in place and part of the plan included actions that would be taken in the event the practice premises were lost due to fire or flooding. The plan identified the use of the facilities of another practice nearby. We saw a letter from the other practice attached to the business continuity plan confirming the arrangement.

All staff received annual basic life support training and the practice had a defibrillator available on the premises and this was checked monthly to ensure it was in good working order. The practice did not have medical oxygen on site. Oxygen is considered essential in dealing with certain medical emergencies (such as acute exacerbation of asthma and other causes of hypoxemia). However, the practice was located near a hospital and had also sought advice from a consultant interventional cardiologist to consider the risk in February 2014. However, a formal risk assessment which included mitigating actions had not been carried out.

The practice had some emergency medicines in the surgery to respond to anaphylaxis, chest pain of possible cardiac origin and for suspected bacterial meningitis. No other drugs were kept in the practice. However, the practice had a written agreement with a nearby pharmacy manger with a list of emergency medicines that would be available when required. The letter was from the manager who supervised two local pharmacies, one of which was open 24 hours a day.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We saw that NICE guidance's were stored on the practice computer system which ensured that staff had access to these guidelines to deliver care and treatment to meet patients' needs.

The practice had a lower rate of unplanned admission to accident and emergency despite being located near a hospital. The practice believed it was because of their commitment to manage the long term conditions of their patients effectively. The practice did not employ a nurse but was high a Quality and Outcomes Framework (QOF) achiever reflecting positive outcomes for patients with chronic diseases, such as diabetes, asthma and hypertension. QOF is a system intended to improve the quality of general practice and reward good practice.

Management, monitoring and improving outcomes for people

The practice used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results were 95% of the total number of points available with an exception reporting of 8%. This was similar to the local CCG and national averages. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

QOF data from 2014/15 showed:

- Performance for diabetes related indicators was better than the national average. The practice achieved 99% of the QOF targets; this was 10% above the national average.
- Performance for mental health related indicators was better compared to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93%. This was 5% better than the national average.

Before our inspection we noted that there was a large variation between the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) compared to local practices. The GP explained that this had been looked at previously and one of the main reasons was due to the patient population registered at the practice.

There had been three clinical audits completed in the last two years. They included an antibiotic audit and an osteoporosis audit. However, these audits did not demonstrate a completed audit cycle. The antibiotic audit was a search to provide data for antibiotics prescribed over a three month time period and did not set any standards. The osteoporosis audit did set standards however, all patients identified in the audit were being treated appropriately and no further actions were identified.

Effective staffing

There was an established team within the practice. We observed that staff knew their patients well and vice versa. This was mainly due to all staff who had worked at the practice for a long time. For example, the newest member of staff had been working at the practice for over 10 years. The team consisted of the provider GP, practice manager, the assistant practice manager who was also the registered manager and non-clinical partner. There was no nurse but there were two healthcare assistants (HCA) that also worked in reception.

The practice was proactive in providing training to staff. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work including online learning. This included core training in areas such as safeguarding children and vulnerable adults and basic life support and infection prevention and control. Staff discussed with us training opportunities they had been given to develop skills in line with their roles and responsibilities. For example, the practice had offered staff the opportunity to train as HCAs. One of the staff members we spoke with told us that they were given time off to attend training for their role as a HCA as well as paying for other courses such as an National Vocational Qualification (NVQ).

Good

Are services effective?

(for example, treatment is effective)

The learning needs of staff were identified through a system of appraisals and meetings. We saw that a number of staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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 investigation and test results. The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We saw many examples where capacity to consent was assessed. For example, we saw example of one elderly patient with regular hospitalisation where advanced decision not to attempt cardiopulmonary resuscitation (CPR) was made. We saw that appropriate paperwork was made available for patients to keep at home as well as ensuring adequate updating of the practice computer system.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. For example, the registered practice manager showed us a website (route2wellbeing) that the practice used and was being promoted by the CCG. This website allowed staff to refer patients to appropriate services such as carers support, sexual health and pregnancy, counselling as well as many other care and social services. The website facilitated this by listing all services available so that patients could access those that are convenient for them.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by providing information leaflet in different languages. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice did not employ a nurse and the GP (male) carried out cervical cytology screening. The GP told us that they were a gynaecologist before they had qualified as family doctor and explained to patients their background. They also explained to patients that there was no female GP or nurse to carry out the procedure when they joined the practice and that most patients were happy with this arrangement. The practice showed us a patient questionnaire where this was explored with patients. If patients did not want the GP to carry out the procedure they would discuss alternative options with them.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. All staff had worked at the practice for a long time and many of the patients we spoke with were also longstanding. We saw that there was a good rapport with patients from staff. It was evident that staff members knew many of the patients and were friendly towards them.

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. If patients wanted to discuss anything in private, reception staff told us that they could offer them a private room.

All of the 26 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a friendly service and staff were helpful, caring and treated them with dignity and respect. We spoke with six patients on the day and they were positive about care they had received at the practice.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 78% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%).
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 97%)
- 75% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%)

The survey showed that patients felt that the nurse was good at treating them with care and concern which was the same as the national average. However, the practice did not have a nurse and patients and this may instead have been for the healthcare assistants (HCAs).

Care planning and involvement in decisions about care and treatment

We spoke with six patients and all of them told us 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. All 26 comment cards we received were positive and aligned with these views of the patients we spoke with. We looked at care plans and saw they were personalised. For example, when capacity and consent was assessed, appropriate plans were in place.

Results from the national GP patient survey showed patients rated the practice below the national average to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 73% of patients said the last GP they saw was good at explaining tests and treatments compared the national average of 86%.
- 71% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 74% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

However, the practice had also conducted its own patient survey of 17 patients for 2015-16 to gauge patient satisfaction with the doctor at the practice. The practice finding was that the overwhelming majority of patients rated the GP about their involvement in planning and making decisions about their care positively.

The practice provided facilities to help patients to be involved in decisions about their care. Most of the staff were bilingual and could speak some of the languages spoken by patients. A translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients that a translation service was available.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. For example, we saw a leaflet on dementia in the Bengali language with contact details of other organisations patients could access for help and advice. The practice also utilised the route2wellbeing website promoted by the CCG to further signpost patients.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified just over 1% of the practice list size as carers. The assistant practice manager told us that over 50% of the patient population were of south Asian origin and although they may have been carers they did not always want to register. We saw written information was available to direct carers to the various avenues of support available to them as well as online support.

The GP told us that each patient's family were dealt differently when they had suffered bereavement and spoke to us of recent examples. They said that they had a diverse mix of patients with different cultural needs and expectations. They also told us that they had long standing staff and knew the patients and their families well and spoke to them and offered appropriate support. Sometimes staff members visited families in their homes to offer support.

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 plan services and to improve outcomes for patients in the area. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. For example, the practice was taking part in the primary care commissioning framework (PCCF) and as part of this was expected to offer various services such as end of life care, improve patient safety though better safeguarding processes and to improve on management of long term conditions.

The practice prescribing was below the CCG targets and so did not regularly work with CCG pharmacists. However, the practice had access to the pharmacists to ensure prescribing was in line with best practice guidelines.

Urgent access appointments were available on the same day for children, the elderly and patients who were vulnerable. This was further facilitated by the walk-in appointment system operated by the practice Mondays to Thursdays. All patients we spoke with told us that they found this useful and did not generally have to wait long.

Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Some of the patients we spoke with confirmed that they had received a home visit from the GP when they were unable to attend the practice due to their medical conditions. We were told that patients on end of life care were given the GPs mobile number for rapid access.

There were extended opening hours on Mondays when it was open from 6pm to 7.30pm and patients could book appointments and order repeat prescriptions online which would benefit patients unable to visit the practice during the main part of the day.

The practice was accessible for patients using a wheel chair as there was ramped access. The practice did not have a hearing loop but staff members we spoke with told us that they rarely needed this as they did not have any patients that needed a hearing loop. Staff told us that if a patient that did struggle with their hearing they would talk slowly face to face.

The practice did not have a nurse and GP told us that they explained to patients that a nurse was not available when they joined the practice. The practice showed us a patient questionnaire which was given to all new patients to complete when first registering. One of the questions asked if patients were willing to be examined by a male doctor if a female doctor was unavailable. If patients were unwilling to be examined by a GP they were advised in regards to alternative arrangements. This included registration with a nearby practice with a female clinician or alternative arrangement for cervical cytology. The achievement for cervical cytology was comparable to the local and national averages.

Access to the service

The practice was open between 9am and 6.30pm daily except on Fridays when it closed at 1pm and extended surgery hours were offered on Mondays until 7pm. When the surgery was closed, the service was provided by an out-of-hours provider. The practice offered walk in clinics in the mornings except for Fridays. All patients present in reception by 10.30am were seen by the GP on a first come first seen basis. In the afternoon, the practice was open from 5pm to 6pm and access to the GP was through an appointment system. In addition patients could have telephone consultations, have home visits where required and make online bookings.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed in comparison to local and national averages.

- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and the national average of 75%.
- 92% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and the national average of 73%).

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 complaints and comments leaflet available in the reception area with a form for

Good

Are services responsive to people's needs?

(for example, to feedback?)

making complaints or comments. The practice manager was the designated complaints lead and patients were advised to discuss any issues with them at the first instance.

The practice had a comments book in reception area and we saw that six comments were received for the year 2015. We saw all the comments were positive about the service and staff.

The practice had also received one complaint regarding a staff member in January 2016. We saw that the practice had identified learning and the patient received an apology and was happy with the outcome.

The practice also carried out patient surveys to monitor and improve service and we saw that the findings of the survey were positive. Some patients had requested weekend opening hours but the practice was unable to offer this currently and the practice survey showed that most patients were happy with the opening hours.

The registered manager also told us that they monitored the practice performance by analysing the national GP patient survey. They told us that patients had rated then lower for availability of appointments compared local CCG and national averages. However, they showed us the appointment system on the day of inspection and we saw that appointments were usually available for most days we looked at. Reception staff we spoke with also told us that patients did not need to book an appointment to see a GP in the mornings. The surgery operated a walk in appointment system and always had capacity. Patients we spoke with on the day of the inspection confirmed that they were able to get appointments when needed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear objective to deliver excellent service to patients that they knew by name rather than a number. Minutes of practice meeting we looked at showed that individual patients were discussed with follow up actions. We saw that the practice staff knew the patients well and the patients knew staff well on the day of the inspection.

Governance arrangements

There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The practice manager was responsible for the day to day management of the practice and the registered manager assisted the practice manager. On the day of the inspection the practice manager was away and the assistant practice manager was unable to locate some of the information that we had asked. We noted some minutes of meetings were not formally recorded and the infection prevention policy had not been reviewed.

The practice did not employ a nurse but its QOF achievement suggested positive outcomes for patients with long term conditions. Minutes of meetings that were available showed that complex patients or those with additional acute needs were discussed implementing any care plans where appropriate.

Leadership and culture

Staff members we spoke with told us that they were approachable and always took the time to listen to all members of staff. Most of the staff were long standing members of the team and knew their patients well.

There was a clear leadership structure in place and staff felt supported by management. Staff members were supported financially to train as healthcare assistants (HCAs). Staff told us that regular meetings were held. However, records we looked at showed there were gaps between May 2015 and February 2016. We were told that being a small practice they did not always hold formal practice meetings as they communicated with each other regularly. However, multidisciplinary meetings with other professionals were held monthly and we saw records to confirm this.

The provider was aware of and complied with the requirements of the Duty of Candour. For example, we saw that an apology was made to a patient after they made a compliant.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. It sought patients' feedback and engaged patients in the delivery of the service. Feedback from patients was gathered through the Patient Participation Group (PPG) and through surveys and complaints received. Records looked at showed that the practice PPG had last met in February 2016. Some of the concerns from a member were the lack of privacy at reception due to the small area. The practice discussed moving some of the chairs away from the reception desk.

The practice had also conducted its own survey with 17 patients taking part for 2014/15. Feedback received was positive in regards to the care being delivered. The practice also monitored the national GP patient survey results and was able to show they had considered areas where areas for improvements were identified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person did not ensure safety and welfare of service users by ensuring those staff that undertook clinical duties as well as those carrying out the role of a chaperone have robust risk assessments in place to support decision not to carry out a DBS check. This was in breach of regulation 17 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.