Park View Surgery

Quality Report

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

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Summary of findings

Overall summary

Park View Surgery provides services that include access to GPs and nursing staff for diagnosis and treatment of conditions and illness, minor surgical procedures and ante and post natal health care for mothers and their babies.

Patients of the practice can access extended hours provision one evening a week at the practice. At all other times out of hours primary care is provided by Preston Primary Care Services at Preston Hospital.

Patients are positive about their experiences when they use services at Park View Surgery. Staff and patients have opportunities to influence how the practice delivers services.

The practice provides treatment from a building that is clean. Staff regularly monitor different aspects of the service to ensure standards remain satisfactory.

The practice is registered to provide the following regulated activities: treatment of disease, disorder or injury; diagnostic and screening services; maternity and midwifery services; and surgical procedures.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Most aspects of the service were safe. The practice had dedicated systems in place to identify and respond to risk and unsafe practice. Not all the staff had been appropriately checked to ensure they were suitable for their role.

Processes were in place to identify risks, risk management plans were developed to ensure the risks were reduced and steps were taken to improve practice as a consequence. The practice took steps to develop staff understanding of specific locality concerns including working with vulnerable groups and any associated risks.

Are services effective?

The practice was effective. The GPs and practice management were involved in local management forums to ensure services and responses to issues were considered in line with current best practice guidelines. Patients were confident their needs were met by the practice or by referral from the practice. Practice staff were suitably qualified to meet patient needs. The practice worked well with other professionals to meet the needs of a diverse population group.

Are services caring?

The practice was caring. Patients we spoke with, and those who completed the CQC comment cards, spoke favourably about the practice. Patients told us they were treated with respect and involved with their care and treatment. Patients who could no longer give informed consent were supported by best interest decisions and offered support from external specialist providers.

Are services responsive to people's needs?

The practice was responsive to the needs of patients. The practice understood the complexities of the local population and took proactive steps to best meet their needs. The practice acted on suggestions made by patients and was scoping interest in a Patient Participation Group (PPG). A clear complaints procedure was available.

Are services well-led?

Most aspects of the service were well led. Risk management systems were clear and effective but also flexible enough to manage the changing risks of a diverse patient group.

Summary of findings

Staff were committed to maintaining and improving standards of care. The practice had developed systems that supported learning and promoted an open and fair culture.

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 offered a health check for patients over the age of 75 years. Patients were able to drop in to dedicated clinic slots for this purpose. The waiting room had a table display of leaflets offering support services for patients over 75. Available support included home help, age concern, foot care and living with dementia.

The practice had a dedicated service for the over 75 year old patients. Each patient had a named GP and there was an annual review for any patient diagnosed with dementia which included an assessment of mental and physical health care needs. The practice worked with patients' social workers and had recently introduced a falls risk assessment in an attempt to better manage patients at risk of falls.

People with long-term conditions

The practice did not have specific clinics for long term conditions and saw patients within normal appointments. The practice found there was a better take up of appointments if they were more flexible. The practice nurses led on management of most long term conditions including reviews and follow ups. The practice nurses would visit patients in nursing homes for their reviews if it was required.

The practice understood the diverse population groups living with some long term conditions. Practice staff could communicate why certain conditions were more difficult to manage than others. For example the impact of economic constraints on appropriate diets for patients living with diabetes.

Mothers, babies, children and young people

The nurse prescriber was the lead for women's sexual health and family planning.

The practice held a weekly baby clinic. The nurses identified concerns on waiting times and as a result extended the clinic over two rooms with two staff. Waiting times have much reduced. There was a dedicated notice board and waiting area for mothers and babies. Information included support with breast feeding and sleeping babies.

The practice participated in local forums to support teenagers. Sexual health clinics have been set up to better support and focus on this population group.

Summary of findings

The working-age population and those recently retired

The practice had information to support patients with health promotion which included dealing with busy lives. Extended opening times were offered one evening a week to support patients wanting to access an appointment outside of normal working hours.

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

There were a number of hostels and supported housing schemes within the practice catchment area. The practice was the sole GP for a female probation hostel and a homeless hostel.

One of the GPs worked with the Community Drug Team (CDT) to prescribe medication to support patients' to sustain a substance free life. Support agencies such as Help Direct held drop in clinics at the practice to support patients with needs other than health care including housing, benefits and employment/training.

People experiencing poor mental health

The practice worked with 144 patients who were experiencing poor mental health. The GPs worked with local specialist teams to support patients with poor mental health. A local supported housing scheme worked with young people with autism. The practice worked with the scheme to ensure patients were supported by the health service as required.

The practice had regular meetings with the local specialist mental health team to discuss some of the patients the practice worked with. The patients involved were invited to the meetings. Local commissioners were informed of gaps in provision to support these vulnerable groups.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of the inspection. We looked at 19 completed CQC comment card. We spoke with patients from different backgrounds and with different health needs. Everyone we spoke with was positive about their experience at the GP practice.

We were told all staff had time to spend with patients. Patients felt they were important and the staff genuinely cared for their wellbeing.

GPs and nursing staff were praised for their ability to diagnose and treat conditions quickly. Patients felt the practice made a difference and promoted their good health.

Areas for improvement

Action the service MUST take to improve

Recruitment procedures were not consistently followed across clinical and non-clinical teams. Some checks on suitability to post had not been completed including registrations and Disclosure and Barring Service (DBS) checks.

Action the service SHOULD take to improve

The recent health and safety assessment had not identified the requirement for the electrical hard wired system and gas installations to be checked.

Not all staff had completed both vulnerable adults and children's safeguarding training.

A copy of the business continuity plan was not available to all staff at the time of the inspection.

There was not a central record of staff training

Most staff had not received an annual appraisal for some time

There was not a central source for clinical policies and procedures. Procedures we saw were not always replicated in practice. Some protocols had not been updated for some time and there was not a version control system in place.

Park View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP and a practice manager.

Background to Park View Surgery

Park View Medical Centre is situated close to Preston city centre. There are three partner GPs supported by up to three trainees and registrars. The clinical team includes the GPs, two practice nurses, a phlebotomist and a full time health care assistant role. The practice has a manager and deputy and also a secretary. The seven reception and administrative staff included some staff trained to make up some of the clinical team.

The practice is open Monday to Friday from 8am. The practice closes at 6pm except for an early 1pm close on a Thursday afternoon and extended hours access to 8pm on a Monday. Treatment advice outside of this time is available from the website and from the national '111' number. Access to appointments is available out of hours from Preston Primary Care Centre at the Royal Preston Hospital.

The practice serves the greater Preston community and has a current patient list size of 5433. The patient population comprises of less than the England average of both under 18 year olds and over 65 year olds. The population area is mixed and includes, patients from both lower and higher socio/economic backgrounds. The area also has a large ethnic population.

Why we carried out this inspection

We inspected this out-of-hours 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?
- 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 our inspection we reviewed information we hold about the practice and asked other organisations and key stakeholders to share what they knew about the practice. We analysed information received through our intelligence

Detailed findings

monitoring system and reviewed policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 11th July 2014.

During our inspection we spoke with a range of staff including; GPs and a foundation doctor, practice nurses, the phlebotomist and a health care assistant, the practice manager and reception and administration staff. We spoke with eight patients on the day of the inspection and reviewed 19 CQC comment cards available for patients to complete on the day. We observed how patients were being cared for and reviewed documentation as required. We also requested some information to be emailed to us following the inspection.

Are services safe?

Our findings

Some aspects of the service were safe. The practice had dedicated systems in place to identify and respond to risk and unsafe practice. Not all the staff had been appropriately checked to ensure they were suitable for their role.

Processes were in place to identify risks, risk management plans were developed to ensure the risks were reduced and steps were taken to improve practice as a consequence. The practice took steps to develop staff understanding of specific locality concerns including working with vulnerable groups and any associated risks.

Safe patient care

The practice had a comprehensive process for recording, analysing and reviewing events related to patient safety. Named leads for tasks ensured actions were completed and any lessons learnt were shared and used to improve patient care.

Records were kept of significant events on a standard template which included a risk score and importance level. Details were also kept of any changes made to practice or policy as a consequence of the event.

Learning from incidents

There was a system in place to ensure staff learned from any incidents. Informal discussion around safety alerts took place regularly as they were received. Steps were taken and any areas of concern were addressed. Incidents and alerts were discussed more formally at risk stratification meetings and monthly clinical team meetings. It was not always clearly minuted what action had been taken as the result of a safety alert but audit trails were available through changes in practice including prescription types.

Safeguarding

One of the practice partners acted as the safeguarding lead. They were suitably trained and were also the local lead for the Out Of Hours (OOH) service. One of the partners was responsible for safeguarding with the Clinical Commissioning Group (CCG).

There were posters displayed in the waiting room on how to access support for domestic abuse. There were details of procedures for reporting vulnerable adult and child abuse.

Staff received level one safeguarding training as part of the practice induction and thereafter annually. The safeguarding lead had recently sourced an E-Learning course for the Mental Capacity Act (MCA) 2005

Most staff had undertaken safeguarding training but not all had completed both vulnerable adults and children's safeguarding training. However Protected Education Time (PET) sessions had been held quarterly to discuss vulnerable adults and clinical examples had been used to bring the sessions to life. Examples used were specific to the practice area.

Monitoring safety and responding to risk

Different staff groups held meetings to discuss and manage their area and workload. Additional PET sessions were organised monthly to discuss significant events and practice improvement. Discussions around specific risks were held and all staff both administrative and clinical had opportunities to ask questions and be involved with improvements. Recent discussions had been held around outlier areas including emergency admissions and falls. Agreements and actions were taken from the meetings and issues were looked at further if required. For example patients were audited to determine those with a high falls risk. Care plans were developed to include specific codes to ensure support was delivered appropriately.

There were smoke alarms in the communal areas and emergency exit signs above door ways. Fire extinguishers were available in the corridors. Checks were completed to test equipment was in good operational order.

Arrangement were in place for risk assessment to be completed at the practice. The gas installations were due to be serviced on the 29th August 2014 and the safety of the electrical installations had not been checked since the building was refurbished nine years ago. Plug sockets in the waiting room did not have protective covers on them.

Medicines management

The practice had a medicines coordinator who took the lead for prescriptions, costing, queries and the administration of medicines. The coordinator held a PET session twice a year to formally update the team on everything that had changed since the last session. The coordinator would ask the practice manager to update the team formally through monthly team meetings or via email of any changes as they occurred.

Are services safe?

The practice worked with local pharmacies and managed a repeat dispensing service though the pharmacy. Repeat dispensing is where a repeat prescription service is offered by the pharmacist. The service allowed patients to obtain their regular prescribed medicines from a community pharmacy for an agreed length of time. The pharmacy monitored the patients and their medication and referred them as required back to the GP.

The system for completing medication reviews had recently been changed. The nurse or administrative staff wrote on the patient notes that a review was due. When the patients arrived for appointments the reception staff informed the GP. This helped give the GP every opportunity to complete the medication review within agreed timescales. GPs had an allocated afternoon per week to work through medication reviews without interruption.

Routine prescriptions were printed for the duty GP to sign and acute prescriptions were sent through as a request task to the GPs. Uncollected prescriptions were checked after three months and destroyed. We discussed with the practice manager the concerns around someone not collecting a prescription. This was acknowledged and a specific prompt was to be added to prescription reviews where someone may lack capacity.

The practice had a comprehensive repeat prescribing policy. An appointed member of staff had responsibility for the daily collection and processing of all repeat prescription requests. Repeat prescriptions could be booked online through the website, via telephone and in person. Prescriptions were usually ready within 48hours. We were told of two occasions when this had not happened but the issues were resolved following input from the practice manager.

The practice held two fridges one for vaccinations and items that required refrigeration and another for samples to be sent to the laboratory for checking. There were no controlled medicines on site.

A stock of emergency medicines was held in a cupboard in the practice nurses' room. Two of every item was kept. An emergency medicines kit was also kept in the main reception area. Medicines were not easily accessible as there was a large supply and they were not organised within the reception kit. All medicines held on site were checked every month, we could see from records new medicines had been ordered when best before dates were due to expire. It was not clearly recorded when expiry dates were for all medicines.

Cleanliness and infection control

There were hand sanitizers throughout the practice for use by staff and patients. Staff told us they had received training in hand hygiene and we saw posters at sinks displaying a good technique.

Routine cleaning was contracted to a specialist external company. A schedule was developed for the contractors to understand the purpose of their work. An infection control policy identified a colour coded system for cleaning equipment to reduce the risk of cross contamination and spread of infection. There were records of cleaning undertaken and schedules were compiled for daily, weekly and six monthly cleaning tasks to ensure the practice, fixtures and fittings remained clean. Cleaning audits were completed internally by the practice manager.

The last infection control audit was completed in June 2014, not all the items identified for action had been completed at the time of our inspection but the infection control lead was aware of what needed to be done and had completed a programme of works to address the outstanding actions.

Sharps bins and foot operated clinical waste bins were in use in the consulting and treatment rooms. Spill kits were available for staff to clean up any bodily fluids. Staff told us they were confident in how to use them.

There were good supplies of Personal Protective Equipment (PPE). Disposable gloves, aprons and other necessary PPE was available in all treatment rooms.

Staffing and recruitment

The practice had not undertaken appropriate checks on the nurses and Health Care Assistants (HCA) including DBS (criminal history checks) at the point of recruitment. We did not see any details of DBS and registration checks for the partners at the practice. Hepatitis B vaccinations were given to health care employees to reduce the risk of infection. We did not see evidence of the clinical staff immunity to Hepatitis B in any files. Recruitment procedures were not consistently followed across clinical and non-clinical teams.

Are services safe?

The practice manager told us if information was not available in staff files that it had not been collated or collected at point of recruitment. We asked for information on DBS applications to be sent to us and the practice manager applied for the checks following the inspection.

As a training practice the practice had three additional doctors at different points of their GP training. The GP trainee we spoke with received supervision once a week ran a joint surgery once a week with a partner GP and had an hour tutorial. We were told the partners were careful to ensure the trainees were competent and completed evaluations with some of the patients seen by new trainees at the practice.

Dealing with Emergencies

An up to date business continuity plan was in place. The plan included risk management plans in the event of a number of circumstances that included loss of power and the event of the practice building becoming uninhabitable. A copy of the plan was not available to all staff at the time of the inspection. We were assured this would be rectified.

The lead GP was proactive in assessing the need for additional support for winter planning. A bid for a half time mental health worker had been submitted to support the GPs workload over the winter months. The practice was looking to increase locum doctors to deal with both the winter pressures but also to target the work to understand data anomalies and emergency admissions.

Practice staff were employed for more than one role. Most reception staff were also qualified to undertake the health care assistant role. This allowed for some flexibility to cover sickness and holidays within the current staff team. We were told extra appointments were offered during busy times including after bank holidays. Extra locum GPs were used as and when required.

A panic button system was in place in the practice nurse room. Staff would be alerted and respond as required. The GPs used an emergency generated by emis web (computer system). An alert would be sent and everyone in the practice using the system would be able to coordinate a response. CCTV was used to monitor the stairs and hallways. We were told that staff checked up on each other if they had held a consultation with a patient upon which there was an alert.

The waiting room was open plan and doorways leading to the main part of the building required a code for access. On the day of the inspection both coded doors were open allowing patients to move freely through the building. We were told of two situations when staff had been verbally abused by patients. The rationale for not using the key codes had not been risk assessed. We discussed this and were told a risk assessment would be completed with the involvement of the reception staff.

We were told of situations when emergencies had occurred and how staff had managed them including when a patient fainted in the waiting room. All staff told us they had received annual incident training including CPR, we were told it was organised again for this year. All staff we spoke with knew where the emergency medicines were kept.

Equipment

Emergency equipment including the oxygen and defibrillator (used to restart a heart) were checked monthly. Nebulisers (used to get steroids into the lungs to improve breathing), scales and other equipment was calibrated to ensure they were accurate.

The fridges used by the practice were checked daily and the temperature recorded and monitored electronically. An alarm was also used if the fridge went above or below a certain temperature. The alarm activated an electronic monitoring system to give the practice details of when and for how long temperature deviations were recorded. The fridge whilst new did not conform to recent guidelines stating vaccine fridges should be fused and hard wired to reduce the risk of loss of power.

All the equipment held on site had a certificate to evidence it had been checked or calibrated by a suitably qualified professional to ensure it was fit for purpose.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective. The GPs and practice management were involved in local management forums to ensure services and responses to issues were in line with current best practice guidelines. Patients were confident their needs were met in house or via referral from the practice. Practice staff were suitably qualified to meet patient needs. The practice worked well with other professional to meet the needs of a diverse population group.

Promoting best practice

It was not clear from talking to staff who took the lead for keeping practice protocols up to date. Information shared with CQC prior to the inspection was not reflected within the practice. We found many of the protocols required updating or were not specific to how the practice worked. However when we spoke with the lead GP, partners and clinical staff they were consistent in how services were delivered.

We spoke to the practice manager about management of long term and chronic conditions. We were told about the population tool on the electronic system and how it was utilised to manage the needs of the different population groups. The practice had not developed their own care planning system but fed into other care plans including those of people living in care homes or in receipt of other services.

We spoke with staff about working with patients with limited capacity to make decisions. Clinical and non-clinical staff showed an understanding around some of the issues patients may face. We were told staff would be compassionate and patient. Staff would make good use of all available resources including involving the patient's carer and referral onto specialist services such as the memory clinic.

As part of the checks on patient care for those over the age of 75 a review of available information was undertaken. This reinforced the need for the addition of specific coding to their records for example being cared for or was a carer. GPs followed up with both mental and physical checks on the patients that included memory checks if required.

We discussed capacity and best interest decisions. The safeguarding lead was aware that all staff were not as knowledgeable as would be preferred in this area. Mental Capacity Act 2005 training had been sourced for all staff including the GPs to complete electronically.

Management, monitoring and improving outcomes for people

The practice manager attended a local practice manager forum. The forum discussed improvements and changes to practice regimes. Information was shared with the practice in the monthly practice meetings. These meetings were also used to discuss and monitor quality within the practice.

Each practice completed an annual self-assessment (Quality and Outcomes Framework) QoF against a national set of targets for quality healthcare provision. Data collected from the 2013 QOF showed the practice as an outlier for five items where patient care should be monitored for patients with diabetes. The monitoring not undertaken in the previous 12 months to the data collection included, foot examinations, recorded Body Mass Index (BMI) and a depression assessment as a result of the patient condition.

GPs undertook audits and surveys. Data collected from audits was discussed within clinical meetings and areas for improvement identified. We reviewed five audits. Two were clearly related and included detail of prescribing oral nutritional supplements (sip feeds), recorded BMI and use of the MUST (Malnutrition Universal Screening Tool). Whilst the two audits did not exactly follow the same criteria it was clearly identifiable the action taken and the impact it had on patients. Prescriptions had reduced and those with no identifiable rational for the prescription or without a recorded BMI/weight were reviewed.

The practice had an improvement plan for the next 12 months. The plan was to be more proactive at targeting vulnerable groups as identified by various quality assessments. In discussion with practice staff it was clear the GPs understood the needs of the vulnerable groups with which they worked and also some of the barriers faced by certain groups to improve their health.

We discussed this with the GPs and other clinical staff. Diabetes was monitored under a long term condition banner and as such had processes in place for reviews within specific timescales. Patients were invited in for a

Are services effective?

(for example, treatment is effective)

review of their condition and if unsuccessful after three attempts they were contacted again 12 months later. A new practice nurse had a specific interest in diabetes and described the changes to be made to the review process to ensure more patients were seen within the 12 month window.

The local CCG held a three external PET (Protected Education Time) session attended by the practice. The sessions looked at areas of interest or concern across the CCG area. Practice clinicians had the opportunity to discuss and agree actions for improvement or to share mitigating circumstances.

Internal clinical meeting minutes included action and improvement plans. This included a medicines optimist pharmacist undertaking a review of prescribing methods across both quality and cost. Administrative and clinical issues were discussed and issues such as training suggested for sustained improvements.

A Multi-Disciplinary Team (MDT) meeting had been held to discuss areas of concern and specifically emergency admissions. The practice had been identified as an outlier with a change from performing much better than comparable practices to performing worse than its comparator group. The practice was working with partner services to understand and address the issues around emergency admissions.

Staffing

The majority of the staff at the practice had been employed for several years. The lead GP was revalidated in January 2014. Revalidation was introduced in 2012 to protect, promote and maintain the health & safety of the public by ensuring proper standards in the practice of medicine. Revalidation requires GPs to provide evidence that they work within robust local systems that support high quality care in the organisations and systems where that care is delivered.

A nurse told us they had received an induction at the start of their employment but there was no evidence of this in the staff files. We were told support was offered whenever requested and the manager's door was always open if staff had any questions.

Staff told us they could access support when they wanted and staff we spoke with knew who to turn to for specific advice. A whistle blowing policy was available and staff knew how to access it and were confident in how to report other staff if they did not think their conduct was acceptable.

We were told staff received annual CPR training and could request additional training if they wanted. Staff we spoke with were confident additional training would be supplied if they requested it. We spoke to different staff that undertook specific roles and were told training had been offered to support that role, this included training in using a spirometer for nurses working with patients and Chronic Obstructive Pulmonary Disease (COPD)/asthma reviews. There was not a central record of staff training and the only way to review records for expiry and due dates was to look in individual personnel files.

Clear lines of management allowed for the responsibilities of supervision and appraisal to be shared across different staff groups. All but one of the files we looked at did not include an appraisal undertaken within the last 12 months. Most staff had not received an annual appraisal for some time. However staff we spoke with said they had enough clinical support to effectively carry out their role.

We spoke with a trainee GP who had worked at the practice for three months. We were told the partners were very supportive of them and included them in the decisions around patient care. Staff told us they felt listened to and when issues arose the root cause was found and the situation improved.

Working with other services

The practice served a diverse population and had a number of visiting clinics to support their needs. Visiting professional included drug workers, podiatrists and Help Direct. Help Direct was a generic support service offering services to help people live independently; services included learning and leisure, mobility and transport and health and fitness.

One GP worked directly with the local Community Drug Team (CDT) to support the needs of patients with substance misuse issues.

A monthly Multi-Disciplinary Team (MDT) meeting took place to discuss patient needs. Attendees included district nurses, social workers, mental health workers and the community matron. GPs also attended the meeting to support discussion around support for specific patient groups.

Are services effective?

(for example, treatment is effective)

Quarterly meetings took place with the palliative care team to discuss on-going support for those patients reaching the end of their life. GPs rotated their attendance at the meeting and the local hospice staff attended as they could.

The practice shared information with the Out Of Hours (OOH) service as required. This included decisions patients had made around their end of life care. The practice used a generic template to share this information with other agencies including the local ambulance service. Sharing information of this type helped ensure patients received the care they wanted at the end of their life.

Each morning the practice secretary took account of any electronic notes from the OOH teams. The secretary would amend patient details if appropriate or send on to the GP as a task.

The practice clinical team worked closely with the local District Nurse (DN) team and faxed relevant information through to them for inclusion within the patients care plan.

GP and nursing staff visited local care homes as required. Summary sheets of relevant information were taken to each location. The information included any specific information the GP may need to monitor or treat patients safely, including allergies, open alerts etc.

We spoke with patients who were confident in the practice and how it worked with other partner NHS services. We were told GPs acted in a timely manner to make referrals to secondary services (hospitals) when required.

Information was available in the reception about the patient summary care records and who else may access the information within them. Sharing some specific patient information with other services allowed external services to work with patients quicker than if the information was not available.

Health, promotion and prevention

The practice had two waiting rooms over two floors. Each room had a selection of health promotion posters and leaflets. The ground floor leaflet display was blocked by a large self-testing blood pressure machine. We discussed this with the practice and were told the waiting area would be re-developed to make better use of all available space.

There was information for patients around managing their own conditions including the Desmond Programme for patients at risk or with type 2 diabetes. The practice had identified this group required additional support and invested in a programme of modules for self-management of the condition.

All new patients whether temporary or permanent had a health check at their first appointment. The check identified any immediate health care or social care needs and included details of habits that could be detrimental to patients health including smoking and drinking.

A white board on the reception wall informed patients of which GPs and visiting professionals were on site. On the day of our inspection the podiatrist was in, as was the support agency Help Direct.

Are services caring?

Our findings

The practice was caring. Patients we spoke with, and those who completed the CQC comment cards, spoke favourably about the practice. Patients told us they were treated with respect and involved with their care and treatment. Patients who could no longer give informed consent were supported by best interest decisions and offered support from external specialist providers.

Respect, dignity, compassion and empathy

The eight patients we spoke with and the 19 CQC comment cards we reviewed all spoke highly of the practice and all the staff. Everyone said they were treated very well with six stating they believed the practice and GPs were the best in the city. The only negative comments reviewed were around access to appointments. Three patients suggested a weekend surgery would support working people better. Four patients said they had to wait over a week to see a doctor of their choice but also said they could see another GP if an emergency. Two patients said it was difficult to get through at 8am when trying to book an emergency appointment.

Patients told us staff took time to listen to them, treating them with respect at all times. We saw consultation rooms were private and patients told us they could organise a chaperone during examinations if required.

The main reception room was open plan and patients said staff were discreet when talking to them about sensitive and personal information. One patient suggested a notice offering a confidential space would benefit those that did not feel they could ask to talk in confidence.

We were told all telephone calls were recorded and the practice had training sessions on customer service where calls were listened to and areas of improvement identified. Reception staff we spoke with had completed a National Vocational Qualification (NVQ) in business studies which included working within equality and diversity standards.

There was no available information on bereavement. We informed practice staff about this and they were to access literature for this type of support. The GP confirmed they did refer patients to the Cruse Bereavement Care Programme where they have required additional support when faced with bereavement. Staff we spoke with showed an understanding and empathy when discussing bereavement.

Involvement in decisions and consent

Patients told us they never felt rushed during appointments and their opinion was always sought and considered when advising of treatment or medication. Patients we spoke with said they understood their condition and their diagnosis had been discussed with them in a way they understood.

Patients we spoke with were aware of the chaperone procedure and knew how and in what circumstances to request one. Patients who had taken family members into treatment rooms to see the GP with them all said it was not a problem. GPs told us they involved carers and family members when explaining specific treatments. Patients told us the GPs had a good relationship with family members and carers.

The consent policy considered when it would be appropriate to act on a patient's implied, written and verbal consent to treatment, immunisation or investigation. The consent procedure required the GP to sign stating they had informed the patient of the procedure in a way they understood. The Gillick competencies were explained when asking younger patients to give their consent and understanding of diagnosis, treatment, risks and issues and consequences. Procedures were also available for patients to agree to students sitting in on consultations.

The practice regularly completed mental capacity assessments when they believed patients could no longer give informed consent. Referrals were made to the memory clinic and best interest decisions made as required. GPs completed annual reviews with patients who lacked capacity and an assessment on on-going capacity concerns would be undertaken at this point.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to the needs of patients. The practice understood the complexities of the local population and took proactive steps to best meet their needs. The practice acted on suggestions made by patients and was scoping interest in a Patient Participation Group (PPG) A clear complaints procedure was available.

Responding to and meeting people's needs

The practice reception desk was on a higher level to the waiting room. The higher level was accessible by three steps or a disabled floor lift for patients using a wheelchair or with a pram. GPs saw patients using a wheelchair in ground floor treatment rooms. Some hallways were narrow but most had hand rails to support patients with restricted mobility. The main front entrance opened automatically as someone approached and there was a help button at a lower level.

The electronic system identified those patients who may require longer for an appointment because of cultural or health barriers. The practice could request support from the CCG for patients who needed a translator for verbal or visual sign language.

The practice offered a number of enhanced services to meet local needs. These included alcohol related risk reduction, learning disabilities health check scheme and support patients who had issues associated with substance misuse. No one member of staff took the lead for any particular service. Learning was shared through open dialogue and through practice meetings. The practice worked in partnership with local services to meet patient needs.

Patients we spoke were all complimentary of how the clinical team moved quickly when assessing they could not meet patients' needs directly at the practice. We were told of immediate referrals and personal phone calls to discuss results from secondary care (hospital) appointments. When required patients were seen as emergencies within hospital clinics and we were told of one patient receiving an operation within two weeks of diagnosis of a cyst.

The practice saw patients in normal or extended appointments for reviews check-up and follow on health care. Patients were recalled via letter for these appointments and reminders were sent out. Where requests for reviews were not responded to the GP would complete the review wherever possible at the next patient appointment.

One patient told us the practice was the cornerstone for all their health care needs. We were told by many patients the practice were good at co-ordinating the care and treatment they needed.

The practice had a quarterly newsletter that identified available services for all of its patients. Services included support groups for carers.

Each GP we spoke with referred to the diverse population the practice served. The practice would register the local homeless people and worked with patients with complex needs including the health risks associated with drug and alcohol misuse. The practice liaised with local commissioners and services to promote provision for the vulnerable population groups in the practice locality. One GP worked with the Community Drug Team (CDT) prescribing medicines to support patients to remain drug free.

The practice held registers of patients with differing needs and conditions. We saw the practice served 351 patients with diabetes, 335 patients with asthma and 144 patients with poor mental health, a learning disability or dementia.

The practice had both male and female GPs and patients told us they could see a GP of choice in non-emergency situations.

Access to the service

Patients told us if they needed a same day appointment they could always get one. Patients would be given one of the daily appointments allocated for emergencies and if these were filled could come and sit and wait until the end of surgery.

The practice leaflet identified how appointments could be made and the different kind of appointments available. These included routine appointments that could be booked two weeks in advance, emergency same day appointments, telephone consultations and home visits where patients were unable to get to the practice.

Patients told us the practice could book double appointments if they thought the GP may need more time. We were also told patients didn't have to wait long after the appointment time if the practice was running behind.

Are services responsive to people's needs?

(for example, to feedback?)

The staff told us babies and children would always be seen in on the same day if requested. Other patients who phoned in the afternoon may need to wait until the next day. The reception staff would liaise with the GP in determining the urgency and need for an appointment.

The practice did not have any allocated disabled parking but a ramp was situated to the front door of the building. One patient with restricted mobility told us the practice organised patient transport for them to be able to access a follow up appointment at another clinic.

The practice had a referral procedure with details of how to refer to third party agencies including St Catherine's Hospice.

Concerns and complaints

The complaints procedure was displayed in the practice waiting room and was referred to on the practice leaflet.

Patients we spoke with told us they knew how to complain but none had felt they needed to. We reviewed complaints the practice had received and they had followed the procedure identified within the practice. An annual synopsis was completed of all complaints for the Clinical Commissioning Group (CCG) detailing numbers and types of complaint.

We did not speak to anyone who had needed to raise a complaint but patients told us they would be comfortable raising concerns with any of the practice staff.

We saw the practice responded to patient feedback. The prescription line had been open from 10am -11am for patients to order repeat prescriptions. Patients suggested the line be open longer. The practice advertised that following patient feedback the prescription line would be open all day on the practice website.

Are services well-led?

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

Our findings

Most aspects of the service were well led. Risk management systems were clear and effective but also flexible enough to manage the changing risks of a diverse patient group.

Staff were committed to maintaining and improving standards of care. The practice had developed systems that supported learning and promoted an open and fair culture.

Leadership and culture

It was clear from talking to patients, clinical and non-clinical staff that the focus of the practice was to deliver exemplary care wherever possible. Practice staff were proud of the challenges they faced and overcame whilst delivering a service to some very vulnerable and potentially challenging patients.

Staff we spoke with described the team as cohesive, supportive and flexible. We were told how the practice would register anyone irrespective of their background or current legal status. Staff said they enjoyed their work and felt supported by their managers. Staff felt part of the bigger practice team.

The practice was soon to become a student nurse placement. The GP partners and current nurses enjoyed mentoring and supporting new professionals into the field

Governance arrangements

The practice had administrative leads for non-clinical areas including infection control and medicines management. Clinical areas were predominantly shared amongst the clinical team.

The nurses were supported to develop areas of interest and become competent in a variety of roles. One nurse we spoke with was clear about how to access support and was proud of how they had developed since being at the practice.

There was a clear clinical and non-clinical line of accountability up to the lead GP and practice manager. Staff we spoke with knew who to go to for specific advice and were confident they would be supported with any issues they raised.

Systems to monitor and improve quality and improvement

The practice was part of a bigger GP practice cluster group. The cluster met monthly to undertake a four month external peer review cycle. The CCG had agendas around specific population groups or aspects of practice which had included prescribing and admissions. The topic would be discussed within the practice group, any actions would be implemented within the practice and any results would be shared back with the practice group. Any changes to practice policy or procedure would be shared via the in house monthly meetings.

Trainee GPs were given half hour slots for appointments. This gave them time to review the patient, check diagnosis and seek support for treatment if required. There was also time for the trainee to record learning points for their own continuous improvement.

GPs reflected at the end of the day on any issues/concerns faced throughout the sessions. Discussions on how things could be improved were shared and then discussed more formally at team meetings.

Patient experience and involvement

The practice did not have a Patient Participation Group (PPG). We spoke with one patient who would be keen to join a group if one was formed. A suggestion box was available in the main reception area for patients to use. The practice had a survey in the main reception area for suggestions and the form included gathering interest in joining an on line Patient Participation Group (PPG). The practice wanted to start a PPG to involve patients more in the practice decisions.

We found patients were very happy with the practice and all the services they received. All patients felt involved with their treatment and felt, where appropriate, they could influence it. Patient preferences were taken into consideration around the type of medicines they were prescribed and where secondary (hospital) treatment would be accessed.

The practice used surveys and questionnaires to gain feedback from patients. A suggestion box was available in reception as was a short survey. Trainees completed questionnaires with patients as part of their evaluation. The practice took steps to act on the information it received. The practice used an electronic checking in system. The system used to tell the patient the time to wait before their

Are services well-led?

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

appointment. Patients had found this frustrating as it did not account for delays and patients who needed more time with the GP. The time patients actually got into to see the GP would be somewhat different to the time they had been told when they checked in. The practice removed this function from the checking in system and patients had said they were much happier. Reception staff would inform patients verbally if the GP was behind schedule.

Staff engagement and involvement

The practice held monthly Protected Education Time (PET) meetings to discuss issues and improvements they wanted to make. All staff said they could contribute and influence the agenda within these meetings. Meeting minutes we looked at confirmed staff could influence decisions made.

Learning and improvement

As a training practice staff were supported through mentorship and guided learning. The practice was hoping to start training student nurses and we spoke to a nurse at the practice who was undertaking the training to be a mentor of the new student nurses.

Training needs were discussed at practice meetings and areas where more support was required were met. The practice had eight internal PET sessions a year to address the training needs identified. The CCG held four PET sessions where practice staff attended if appropriate to do so.

Significant events were discussed and lessons learnt agreed within the team. We were told by all staff that the ethos of the practice was one of continued development and it strived to be the best it could. The practice took on the challenges within the local community and did so within a positive and learning environment.

The practice had a female probation hostel within its boundaries. The practice was the sole GP provider for the hostel. The lead GP was soon to meet with hostel managers to discuss better ways of working together to meet the needs of both the patients and the GP.

We saw all staff had completed a set of mandatory training that included safeguarding and customer care. Clinical staff had all completed emergency Coronary Pulmonary Resuscitation (CPR) training as well as specific training for their role.

Identification and management of risk

All GPs had dedicated slots to catch up on targeted work and assess new trainees. The practice team were aware both from their own internal monitoring and external contract management of the risks to care delivery and success. The GPs had recently recruited a nurse with an interest in diabetes. The practice was supporting the nurse to become a prescriber in an aim to better support the 335 diabetic patients registered at the practice.

The practice was facing increasing demand for same day appointments. Many of these were through crisis management of patient conditions. The practice had developed a more effective way of delivering lifestyle advice in an attempt to reduce patient crisis management. This included the drop in clinics from Help Direct offering more comprehensive support not limited to health care advice and support.

There was not a central source for clinical policies and procedures. Procedures we saw were not always replicated in practice. Some protocols had not been updated for some time and there was not a version control system in place. When we spoke with practice staff about this it was unclear whose responsibility it was to keep procedures up to date.

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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. Patients using the practice and others were not protected against the risks associated with employing staff without the required recruitment checks. Regulation 21 The registered person must; (a) operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying out the regulated activity unless that person is of (i) good character, (ii) has the qualifications, skills, and experience which is necessary for the work to be performed and (iii) is physically and mentally fit for that work; (b) ensure that information specified in schedule 3 is available in respect of a person employed for carrying a regulated activity and such information is appropriate; (c) ensure that a person employed for the purposes of carrying on the regulated activity is registered with the relevant professional body where such registration is required.