

Stoke 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stoke Road Medical Centre on 18 December 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and effective services. The practice is rated as good for providing caring, responsive and well led services. It also required improvement for providing services for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks and fire safety.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were usually 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.
- Patients said there were urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

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

Importantly, the provider must:

Summary of findings

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff receive an appraisal as set out in the practice policy.

In addition the provider should:

- Improve the infection control audits to cover all practice and produce an annual statement.

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?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Lessons were learnt and areas identified for action as requiring improvement were communicated to all staff members. Staff demonstrated understanding of their roles and responsibility to report safeguarding concerns. Improvements were needed with regard to staff recruitment processes, infection control audit and fire safety checks.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services. Patients were treated in line with best practice and current national guidance. The practice had identified areas where action was needed to make sure reviews of patients with long term conditions were carried out and had implemented arrangements to manage and to encourage patient attendance. Staff were able to receive training appropriate to their roles and further training needs were identified and planned for through the appraisal system, although this was not consistent. Patients who had complex needs, such as those at the end of life, were discussed at multidisciplinary meetings.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services. We found that patients were treated with compassion and respect and their privacy was maintained. Patients said they were involved in care and treatment decisions. Staff were observed treating patients with dignity and respect, however there were some concerns about how reception staff interacted with patients. The practice provided information in accessible formats to assist patients in understanding the care and treatment options available to them.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patients reported that they were able to be seen on the same day if their concerns were urgent. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well led. The vision and values of the practice had been communicated to all staff members. There were effective day to day working arrangements within the practice, with staff having clear roles and responsibilities. The practice monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The practice proactively sought feedback from its patient participation group and staff and patients and this had been acted upon.

Good



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 provider was rated as requires improvement for safety and for effective. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for safety and for effective. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Requires improvement



Families, children and young people

The provider was rated as requires improvement for safety and for effective. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. We saw evidence which confirmed that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The provider was rated as requires improvement for safety and for effective. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). 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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Extended hours appointments were available which were aimed at those with working or caring responsibilities.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated as requires improvement for safety and for effective. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for patients whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told 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.

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for safety and for effective. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including iTalk a telephone base counselling service. Information on self-management of conditions was also provided by the practice.

Requires improvement



Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection and reviewed 21 comment cards which had been completed in the two weeks leading up to our visit. Five patients provided positive feedback on making appointments and the appointment system as a whole. Two patients did not find the appointment system helpful and on occasion

found reception staff to be unhelpful. One patient was not aware of evening appointments. Comments cards showed that most patients found the reception staff to be courteous. All patients considered they were cared for and treated with dignity and respect.

Areas for improvement

Action the service **MUST** take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff receive an appraisal as set out in the practice policy.

Action the service **SHOULD** take to improve

- Improve the infection control audits to cover all practice and produce an annual statement.

Stoke Road Medical Centre

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 GP, a practice manager, a practice nurse and an expert by experience. (Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.)

Background to Stoke Road Medical Centre

Stoke Road Medical Centre is situated in purpose built premise at 66-68 Stoke Road, Gosport. PO12 1PA. The practice has existed in Gosport since the late 1800s and has been at its present site for the past 21 years. The practice has approximately 8,500 patients registered with it. The practice area has a higher number of patients who are older; who have cancer; and have long term conditions such as depression and asthma, when compared to the national average. The practice also cares for 72 patients who live in care homes.

The practice has a total of six GPs who work a whole time equivalent (WTE) of 4.9. There is one nurse practitioner, two practice nurses and 2 health care assistants who provide clinical support to the GP partners. In addition there is a team of seven part time receptionists and a practice manager, who is also a non-clinical partner of the practice.

Stoke Road Medical Centre has opted out of providing out of hours service which are provided via the NHS 111 service.

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

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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 18 December 2014 at Stoke Road Medical Centre. During our visit we spoke with a range of staff which included GPs, nurses and reception staff. We spoke with 11 patients who used the service. We reviewed 21 comment cards where patients and members of the public shared their views and experiences of the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our

Detailed findings

areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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

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

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

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

Are services safe?

Our findings

Safe track record

The practice used range of information to identify risks and improve patient safety. Significant events, incidents and national patient safety alerts were recorded, shared and learned from. Comments and complaints received from patients were reviewed and learned from. The staff we spoke with were aware of their responsibilities to raise and report concerns.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had recorded significant events and learning was identified and action taken.

Learning and improvement from safety incidents

National patient safety alerts were disseminated by the practice manager to relevant staff to act on. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings and minuted to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Alerts were usually received via email and circulated to the appropriate staff groups for action. For example, when a medicine alert was received, staff were required to initial a paper copy of the alert to indicate they had read it; the initialled copy was then scanned into the computer system and saved. Urgent alerts were scanned into the system and actioned immediately when these were received.

The practice had a system in place for reporting, recording and monitoring significant events. There was a specific proforma for staff to complete when a significant event occurred. All significant events were reviewed annually at a specific meeting to identify trends and monitor actions taken. Staff said, and minutes of meetings confirmed this, that issues were discussed at daily meetings and action plans put into place and monitored. An example given related to prescribing of steroid medicines when it was identified that patients repeat prescriptions were not being monitored effectively. Action was taken to ensure that prescriptions were accurate and necessary. Significant event forms were stored on the shared drive of the practice's computer system. All staff who needed to be aware of significant events were provided with minutes to read. Paper copies of incidents were also held at the reception desk.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect patients from harm. We found that all GPs had received training at level three for child safeguarding and there was an identified lead on safeguarding adults and children for the practice. Staff had received training on safeguarding at protected training afternoons which are held in the clinical commissioning group area. We saw child protection policies were displayed and contained details of relevant agencies to contact if there were any concerns, such as social services.

There was a system to highlight vulnerable patients on the practice's electronic records. For example, a flag was placed on children's records if they were at risk. Staff we spoke with were able to give example of when they had had to use safeguarding procedures. Such as, when a child was displaying behaviour of concern, a receptionist discussed this with a GP and a safeguarding referral was made.

Patients were routinely offered chaperones, and this was recorded. Nurses and health care assistants at the practice acted as chaperones. There was a clear chaperone policy displayed in the waiting area and in consulting rooms. Detailed information on chaperones was also available on the practice's website. Patients were aware of the chaperone policy and said they would request one if needed. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.)

Medicines management

There were systems in place for managing medicines within the practice. Suitable lockable cupboards were provided for medicines to be stored securely. There was a designated refrigerator for storing medicines which needed to be kept at a low temperature. Records we looked at showed the refrigerators were operating within safe limits. The practice had procedures in place for managing a failure in the cold chain storage of vaccines, this has recently occurred in November 2014, when the fridge door had been left open; in response to this the practice destroyed all the vaccines and reviewed their policy and procedures to prevent reoccurrence. This was recorded as a significant incident.

Are services safe?

Nurses who worked at the practice were responsible for managing medicines kept in the practice. We found these were checked regularly and recorded. We found all medicines were within their expiry date and safe to use.

The practice had carried out seven medication audits in response to meetings about medicines prescribing. Records showed that when needed appropriate action was taken. For example, the practice identified that there was a higher than average use of medicines to treat patients with neuroendocrine tumours and reviewed patients records to ensure these medicines were still relevant. (Neuroendocrine tumours can be cancerous or non-cancerous and there are different types depending on the specific cells affected and are rare.)

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We noted that flooring in the practice was in the process of being replaced with a type which could be easily cleaned.

There was an infection control policy in place and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The practice had a nominated infection control lead and training had been provided to some staff at a training afternoon. The lead said that they visually checked the premises and monitored the cleaning schedules, but had not carried out a full audit of infection control processes or produced an annual statement related to whether systems were safe.

A risk assessment for Legionella had been carried out and had been sent to an external laboratory for review.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

The practice had a recruitment policy in place. However, the policy did not include the full list of the required documents under the staffing regulations of the Health and Social Act 2008. For example, identification checks, qualification checks, full employment history with a satisfactory explanation of gaps in employment. The policy did not outline which staff roles required a Disclosure and Barring Service (DBS) check. We were told that all clinical staff would receive a DBS but the records kept were not complete. We looked at a sample of staff files and found that evidence needed as detailed in the regulations was not present in all of the files. For example, one file did not have evidence of satisfactory conduct in previous employment; there was no risk assessment in place to explain why DBS checks were not required for clerical staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Health and safety risk assessments had been carried out in each room in October 2014. Action plans were put in place to minimise risk, for example decluttering the reception desk. Fire extinguishers had been service and tested in November 2014 and the fire alarm was tested in December 2014.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were

Are services safe?

in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. A nurse who carried out vaccinations in the community said they always took an adrenaline pack with them, in case of allergic reaction.

A fire risk assessment of the premises had been carried out 2009. Staff said there had been a fire drill two week prior to

our inspection, but members of staff involved had not been recorded. Staff were able to explain where the evacuation point was located. The policy on fire safety did not detail staff members who would act as fire marshals in the event of a fire and be responsible for a safe evacuation of the premises. There was no information on how often staff should receive fire safety and awareness training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used a software system that had assessment and treatment templates based on best practice guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information was discussed at practice meetings and current guidance was disseminated to staff. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions.

The triage system used by the practice for same day appointments assisted in directing patients to the correct health care professionals. Patients who were diagnosed with long term conditions, such as, asthma and chronic obstructive pulmonary disease, (COPD is a condition which causes breathing difficulties), had care plans in place detailing the care and support they needed.

Patients who were vulnerable, such as those with mental health conditions were managed in the community and the practice did not have much contact with them. GPs were able to refer patients to these services, but found that was a varying response of the different teams. They found mental health service for those with dementia and adults were generally good, but the services for children were less responsive. All patients who were vulnerable had a care plan in place. Patients with a learning disability were offered annual reviews and had a care plan in place. The practice was working with other GP practices in the area to coordinated care and treatment for those patients who lived in care homes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of such as patients with

suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Management, monitoring and improving outcomes for people

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, the GP nominated as the prescribing lead had completed an audit on the use of domperidone, in response to a safety alert. (Domperidone is a medicine used to treat nausea and vomiting). As a result of the audit patients who were receiving this medicine were contacted and safer alternative medicines were prescribed when appropriate. The prescribing lead said they attended meetings with other practices six times a year to discuss prescribing patterns in the area and liaised with the practice's nurse prescribers at internal meetings. The prescribing lead was currently working on an audit to review the appropriateness of antibiotic prescribing within the practice.

The practice achieved 97.2% in its QOF results, which was higher than the practice average across England. Specific areas where the practice was above the national average for QOF areas included: patients who were diagnosed with dementia having a face to face review annually; and patients who received the flu vaccination.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. All patients who needed specific care management had a named GP. Information was shared with the out of hours service and don not resuscitate decision were also shared with relevant health professionals.

Doctors in the practice undertake minor surgical procedures in line with their registration and NICE guidance. The staff are appropriately trained and keep up to date. They also regularly carry out clinical audits on their results and use that in their learning.

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice nurses and the nurse practitioner were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. Nurses said that they considered they were supported clinically and had appropriate training to carry out their role. For example, on administration of vaccines. Those with extended roles for example seeing patients with asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice said that they considered mandatory training included area such as safeguarding and basic life support for all staff. Records we saw showed staff had received training on mandatory topics. The practice's appraisal system specified that all staff would have an annual appraisal. There were no records to confirm that all administration and reception staff had received annual appraisals since 2010.

Although there were no formal supervision processes in place for staff, nurses said they had meetings every two months to discuss ideas and share best practice and provide support for each other.

Staff who worked as health care assistants received an induction and in house training on areas specific to their role. On occasion they were supported to gain further qualifications in health and social care, for example National Vocational Qualifications. (These have now been replaced by Care Certificate standards). A member of the reception team had recently completed a management course.

The practice had specific duty GP systems for the mornings and afternoons to reflect the differing workloads. The practice manager was responsible for monitoring overall staffing levels in the practice. They said they had not needed to use a locum GP for over a year, to cover sickness. Any sickness cover had been provided by other GPs in the practice. The practice manager added that if a locum GP was used they had an agency that they trusted to provide suitable staff.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation

has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had a range of formal and informal processes where it worked with colleagues and other services to meet patients' needs. For example there was a gold standard framework meeting monthly to discuss those patients on the palliative care register. Ad hoc telephone conversations were held with mental health teams when needed and also the practice liaised with specialist community nurses, such as those caring for patients with Parkinson's Disease.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and said they were able to use it easily and there was scope for adding additional information when needed. Paper communications, such as those received from hospitals, were scanned and saved into the system on the individual patient record.

A medical secretary was responsible for choose and book referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice was trialling a new system which provided treatment pathways for most conditions.

Consent to care and treatment

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff

Are services effective?

(for example, treatment is effective)

demonstrated an understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Two nurses said they had received training on the Mental Capacity Act 2005 and were able to give us examples of when they would use the best interest decision making process.

Health promotion and prevention

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above the average for the clinical commissioning group (CCG), and there was a clear policy for following up patients who had not attended.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients

registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years.

GPs said there were various support services in the area which they were able to refer patients to, or patients were able to self-refer. Smoking cessation sessions were offered at the practice. The practice website and waiting areas had information on health promotion and self-management of conditions. Such as, sexual health, heart disease signs and symptoms and advice on coughs and colds.

The practice had implemented a programme to screen patients who were at risk of developing diabetes yearly and offered health checks and healthy lifestyle advice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed patients being greeted politely by reception staff. We noted that there was limited privacy at the reception area, but there was a sign indicating that a private room could be made available. A member of the patient participation group said they would visit the practice and observe the reception area. They added that when needed they would advise the GPs on areas that needed improvement, for example if reception staff were abrupt.

We noted from the comment cards and complaints log that there were some concerns raised about the attitude of some reception staff who were thought to be rude and abrupt. There was no indication whether the practice had acted on this information. The majority of comments we received from patient were positive about reception staff and many said they were always polite.

Patients said that the GPs and nurses treated them with respect and their privacy was maintained during consultations. Results from the national patients' survey showed that 92.99% of respondents had a good experience of using the practice.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and those who completed comments cards said health needs were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. For example, a patient said that the GP used diagrams to help explain procedures or treatment. Some concerns were raised with us about receptionists trying to diagnose

condition over the telephone and requesting that patient telephoned the following day for an appointment, even though the patient considered their condition needed urgent attention. A patient said that once they had managed to speak with a GP the care and action was taken to address their needs, but they were frustrated by the attitude of a member of the reception team.

Information from the NHS England GP patient survey showed the practice was performing either above or on a par with the national average for areas such as being involved in care decision making and being treated with care and concern. Overall, 81% of patients surveyed would recommend the practice to others. Results from this survey also showed that 89.85% of patients considered the GP involved them in decisions about care and treatment and the figure for nurses was 90.43%. Both results were slightly above the national average.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice system recorded when patients were carers so they could be offered additional support at during contact with the practice or consultations. Patients receiving palliative care were reviewed with other members of the multi-disciplinary team and the practice's end of life care registered was accessible to out of hour's providers. GPs would contact a family if there was a bereavement to offer support. The practice website also contained information to support patients following bereavement.

Results from the national patients' survey showed that 91.25% of patients considered the GP was good at treating them with care and compassion and the figure for nurses was 86.46%, which was on a par with national results.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had a system whereby when new patients registered with the practice, a GP would check the computer summary of their notes for accuracy. We were told that midwives carried out the majority of pre and post natal care. The practice would see mothers for their post natal check and six week baby check or on an ad hoc basis during their pregnancy.

Longer appointment times were made available for patients with long term conditions and annual reviews. The GPs said that they knew their older patients well, as this population group was stable and many had been registered at the practice for a number of years. They added that when needed compliance aids to take medications were prescribed to assist patients in self-management of their condition. Patients who were on the 2% list who were deemed to be at increased risk of inappropriate hospital admission had their care plans reviewed regularly. Any admission was reviewed by their named GP to ensure it was medically appropriate.

The practice offered a minor surgery service and leg ulcer clinics. The practice had two treatment rooms available for minor surgery procedures.

Tackling inequity and promoting equality

GPs said that there were a low number of patients whose first language was not English, but they had access to interpreting services and some of the GPs were Chinese, Hindi and Tamil speakers. The practice was able to access a British Sign Language interpreter for deaf patients. The practice building was purpose built and complied disability access requirements. There was level access with automatic doors at the entrance. The practice had accessible toilet facilities and a baby changing area. We noted there was space in the waiting area for parents to leave pushchairs and prams, whilst seeing the GP. All consulting rooms were situated on the ground floor.

Access to the service.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The patients we spoke with told us they were able to access urgent treatment if it was required. We were shown the computer system for appointments and found that a routine appointment could be booked four days after our visit. When needed extra slots were created and these appointments were managed by the all GPs who were working on the day. We reviewed data from the national patient survey and found that 83% of respondents were satisfied with telephone access and 85% had a good overall experience of making an appointment. A total of 88% were satisfied with the opening hours of the practice.

Pre bookable appointments were made available daily and patients were able to book appointments two days, one week, two weeks and four weeks in advance. The GPs said the appointments system was continually reviewed and modified in response to patient feedback. For example, patients had raised concerns about telephoning the practice between the hours of 8.30 and 10.30 am and the practice responded by requesting that calls for routine appointments and home visits were made after 10.30am. Late evening appointments and Saturday morning pre bookable appointments were available every third Tuesday and Saturday. These appointments were aimed at those who work full time, have carers who work or those who worked out of the area.

The practice had a system in place in the morning where a duty GP would triage clinical conditions and either provide telephone advice, or ask a patient to visit the practice that day. When needed some of these patients were seen by the nursing team if the duty GP considered that would be more effective. The practice had two nurse prescribers who were able to manage more complex needs. GPs said that appointment availability and skill mix were adjusted according to seasonal demand and proximity to public holidays.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had an electronic checking in system which patients said they found to be useful. The majority of patients commented that on occasion they had to wait a little while to be seen after arriving at the practice, but generally appointments ran on time.

Listening and learning from concerns and complaints

The practice had a system in place to managed complaints. The designated person responsible for managing complaint was the practice manager. There was a procedure in place to ensure complaints were resolve as far as possible to the patient's satisfaction.

The practice manager said they would meet with a patient and try and resolve issues, but if that was not successful then they would request a formal complaint in writing and carry out an investigation and provide a written response. When needed the practice would apologise for any

shortcomings, and advise the complainant of actions taken as a result of their concern. We noted that if a complainant was not satisfied with the response information had not been provided on other agencies they could take their concerns to, such as the Health Service Ombudsman or local Patient and Liaison Services. The practice manager said that complaints were discussed in meetings and recorded, we were provided with a summary of complaints received which confirmed this. The practice had reviewed complaints and we saw evidence of how learning from complaints took place and the actions undertaken to improve the service.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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 gave us a presentation at the start of the inspection and their vision was to deliver high quality healthcare in local setting convenient to their community; to prevent ill-health and improve well-being through diagnostic and screening services and provision of advice to help achieve a more healthy lifestyle; and deliver value for money and ensure efficient use of resources.

The GPs said that to achieve these aims they were working with all staff members to promote a culture of joint working. The partners said that previous management of the practice had not always allowed staff to be involved in decision making. They stated that one area they could improve on was communicating changes with patients and were working with the patient participation group (PPG) and updating their website to provide relevant information. The practice had a strategy in place to govern the development of the practice over the next five years and staff confirmed they were aware of this and about to comment on the plans.

Governance arrangements

The practice had a range of meetings to monitor how the service was operating. These included bi monthly meetings for staff teams, for example nurse and reception staff. Partner's business meetings; twice yearly Quality and Outcomes Framework meetings and quarterly whole practice meetings had recently been put into place.

GPs and other clinical staff had lead roles on areas such as prescribing, safeguarding, infection control and staff training. The practice worked with the local clinical commissioning group and other practice in the area to improve and maintain services provided in the area. The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice policy was to carry out staff appraisals annually. There was a system detailing who would appraise different staff roles. We found that this had not been consistently achieved, with some members of the clerical staff not having an appraisal since 2010 and none of the administration staff also had received an appraisal since this time. Staff said they considered they were supported with clinical matters and with training provided.

Leadership, openness and transparency

A GP told us that the culture of the practice had changed since three of the partners had retired and the leadership structure was flatter and more inclusive. They added that the senior partner oversaw activities in the practice but there was more involvement of other staff members such as the practice manager and nurses, which promoted more cohesive working arrangements.

Staff told us they were starting to be involved in the running of the practice more and were able to speak with GPs and the practice manager about any ideas or suggestions to improve patient and staff experience.

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

We met with the Chair of the PPG who told us about how the group operated. They said they met on a quarterly basis and each meeting was attended by the practice manager; a GP attended every second or third meeting to present a practice report. The PPG published a quarterly newsletter which was made available on the practice website and paper copies in the reception area. The Chair said they tried to feature one of the GPs in each newsletter to give an insight into 'A Day in the Life of a GP' to give patients a better understanding of how the practice ran.

Other information contained in the newsletter included health promotion, such as highlighting vaccinations for flu and shingles. The PPG carried out surveys on behalf of the practice and when needed actions were put into place and monitored. The Chair said the most recent survey focussed on telephone access and practice opening times. They had feedback suggestions to the GPs who had acted upon them, for example setting up text reminders and reviewing extended hours appointments to ensure they were effective.

The practice had a whistle blowing policy in place which detailed the actions they should take if they had any concerns. We found that the policy did not reference any external agencies, such as the Care Quality Commission who they could share their concerns with, if they were not confident about approaching the practice. Staff said they were aware of the policy and would not hesitate to use it if needed, but they found the management of the practice approachable and responsive to their concerns.

Are services well-led?

Good 

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

Management lead through learning and improvement

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. Staff told us that the practice supported them to maintain their

clinical professional development through training and mentoring. Other meetings used for learning and improvement included in house education meetings, practice meetings and external education meetings.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers We found that the registered person had not carried out appropriate checks prior to staff commencing employment at the practice. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) regulations, which corresponds to regulations 19 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. The provider did not have suitable policies and procedures in place to ensure that all required information was obtained prior to a member of staff commencing work at the practice. 21 (a) (b)
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff We found that the registered person had not carried out regular appraisals for staff. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) regulations, which corresponds to regulations 18 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. The provider had an appraisal policy in place, but this was not consistently followed to ensure all staff received a regular appraisal and were supported to carry out their role. 23 (1)