Heatherbrook Surgery - RP Archer and CK Archer

Quality Report

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

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Overall summary

Heatherbrook Surgery is a general practice serving approximately 3,300 patients in the north-west area of Leicester. The practice serves the local community and provides a range of services for the residents in the area.

We inspected the practice on 18 July 2014 and spoke with the GPs, the practice manager, practice nurse, other staff and patients. We looked at policies, systems and procedures to determine if the practice was safe, effective, caring, responsive to people's needs and well-led. We also received information and feedback from the Leicestershire Clinical Commissioning Group (CCG), and reviewed feedback from other sources, such as NHS Choices.

Overall, the practice was effectively meeting the needs of patients . We found that the practice had some areas in which improvements were required. Arrangements related to the management of emergency medicines and risk needed to be more robust in order to ensure patient safety. Improvements were also needed in relation to an awareness of the Mental Capacity Act 2005 and consent to treatment..

We found the practice was caring. The staff we spoke with demonstrated a caring culture towards patients. The patients we spoke with told us they were pleased with the service. People told us the GPs were very kind and considerate.

The practice was responsive and provided services to meet the different needs of the patients at the practice, such as maternity, antenatal and postnatal care, smoking cessation support and immunisations.

The practice was assessing and monitoring the quality of its service provision. It did not have formal systems in place to monitor and improve the quality of services. Some clinical reviews and audits had improved delivery for patients, but routine and regular checks and audits were not always in place.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Systems and processes to ensure the practice was safe required improvement. Arrangements related to the management of emergency medicines and risk needed to be more robust in order to ensure patient safety. Improvements were also needed in relation to an awareness of the Mental Capacity Act 2005, consent to treatment, infection prevention and control and arrangements with regard to safeguarding.

Are services effective?
The practice was effective in meeting the needs of patients. For example, a comprehensive influenza vaccination programme was carried out. Arrangements were in place to work with members of the multi-disciplinary team in the local community. The practice linked with the out-of-hours service to ensure continuity of care to patients.. Patients in need of additional support were identified and their needs addressed. For example, patients with caring responsibilities were identified and signposted to local support services were appropriate.

Are services caring?
The practice was caring. The patients we spoke with told us the staff and GPs were very caring and thoughtful. Patients told us they felt involved with decisions about their care and felt that the GPs understood their healthcare and support needs. We saw that patients were treated with respect by staff at the practice.

Are services responsive to people's needs?
The practice was responsive to individual patients' needs. The practice had made changes to its services after they had been identified by the patient involvement group. Patient involvement (or participation) groups are drawn from patients at GP practices, formed with the objective of working in partnership with GPs to improve services. We saw that the opening hours of the practice had been changed to meet the different needs of the patients. The practice linked with other healthcare providers to support patients' specific health needs.

Are services well-led?
The practice had an open culture where staff felt they could contribute to the way the practice was run. However, the practice did not have a business plan that helped them to direct or target

Summary of findings

their services. Instead, the practice reacted to circumstances, situations or opportunities as they arose. The practice did not have arrangements in place to identify or address the management of risks.	

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice had a proactive and caring approach to managing the health of older people. The practice offered a range of services, for example blood pressure monitoring, flu vaccinations and screening. The practice provided patients with a named GP for all those aged over 75 years.

People with long-term conditions
The practice linked with health visitors and the district nurses as part of multidisciplinary teams to offer care and advice on the management of long term conditions.

Mothers, babies, children and young people
The practice offered services for mothers, children and young people. The practice offered child health surveillance, maternity and postnatal care. The practice had links with the health visitor and offered on going support to patients with medical checks, immunisations, development reviews for babies and support for new mothers.

The working-age population and those recently retired
The practice offered extended opening hours with 7.30am surgeries in the morning four days-a-week and late night telephone consultations until 7.30pm four evenings-a-week. Online booking and prescription arrangements were also available.

People in vulnerable circumstances who may have poor access to primary care
The practice had identified those patients with learning disabilities and offered routine health checks as well as opportunistic health checks when patients attended for other reasons. The practice offered temporary care for those patients with no fixed address.

People experiencing poor mental health
The practice was able to identify patients with mental health conditions and offered information and support as appropriate. The practice had links with specialist agencies and other services to deliver good coordination of care including referrals to those services when patients needed more specialised care.

Summary of findings

What people who use the service say

The feedback we received from patients on the day of the inspection was, mostly, very positive. We spoke with seven patients who attended the surgery on the day of our inspection. They told us that they found the GPs and staff were thoughtful and caring. They found the appointment system worked well and they were usually able to see GPs on the same day.

We also had eight patients' comments card completed. Most of the cards contained observations about more than one subject. The majority of the comments were positive and related to the helpful, caring and thoughtful staff team. We saw only three negative comments. These were about the experience of delays in referral to other healthcare professionals, the arrangements for repeat prescriptions and the abruptness of a member of reception staff.

Most people considered that the service was accessible, with appointments available at convenient times. Some people told us that they felt the surgery was clean and tidy. Others considered they had received excellent treatment from the GPs and that treatment was prompt where the GPs always made time for them.

Areas for improvement

Action the service MUST take to improve

The practice must establish a robust system to monitor and manage risks. There was insufficient information to enable us to understand and be assured about safety with regard to infection control, dealing with emergencies and training in safeguarding.

The practice must ensure there is an effective system in place to gain, review and act upon consent from patients. This system must include the use of the Gillick competency and Fraser guidelines for patients under the age of 16 as well as the Mental Capacity Act (2005).

Action the service SHOULD take to improve

The practice should review the current arrangements for access to the emergency drugs, to ensure there is no delay in the event of an emergency.

All staff should be able to demonstrate an awareness of the Mental Capacity Act (2005).

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspection team comprised a GP specialist adviser, a practice manager specialist adviser, another CQC inspector and an Expert by Experience. An Expert by Experience is someone who has experience of using the services we inspect.

Background to Heatherbrook Surgery - RP Archer and CK Archer

Heatherbrook Surgery provides a range of primary medical services to approximately 3,500 patients from a purpose built surgery building in the north west area of Leicester. The practice has two partner GPs, with plans in place for a new partner to join by the end of 2014. The practice has one nurse, a practice manager and a team of reception and administration staff.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- 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
- Mothers, babies, children and young people
- The 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 inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 July 2014, between 9am and 5pm.

During our inspection we spoke with a range of staff, including the GPs, the practice nurse, the practice manager and administration and reception staff. We also spoke with patients and carers or family members of patients.

Detailed findings

We held a listening event in the community served by the practice to gather views of local people. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice had systems for reporting and recording significant events and complaints that were well established. The practice had made appropriate records of incident they had considered to be noteworthy. On each occasion we saw that the reporting and recording arrangements were clear and had followed the policy and procedures in place. We spoke with staff who demonstrated an awareness of the reporting arrangements and were clear about whom they should approach if the need arose. Staff told us that health and safety concerns were discussed at the monthly 'all staff' meetings, and we saw this was recorded in the minutes of those meetings.

Learning and improvement from safety incidents

Both of the GPs we spoke with told us of their involvement in significant event analyses (SEA). A SEA is a review of a situation or event to establish what happened and why, how things could have been different, what could be learnt from what happened and what needed to change. We found that there was an understanding among the staff of the benefits of an open and supportive culture and this encouraged them to engage in the process openly.

We saw examples of events which had been reported and had been investigated. Outcomes had been reported to the staff team. The incident reports showed that actions had been taken by the practice in response to the SEAs. This indicated a commitment to improving the performance of the practice and identifying where improvements could be made. We also saw that the changes made as a result of the incident investigations had later been reviewed to ensure they worked successfully.

Reliable safety systems and processes including safeguarding

The practice had a recruitment policy which set out the detailed processes to be followed. The staff files we reviewed demonstrated that the policy and procedure had been followed appropriately. We saw that the practice had undertaken background checks before staff commenced employment, with personal and professional references obtained so that the practice could be satisfied they were safe to employ. For clinicians we saw that the procedure included checks with appropriate professional registration bodies

One of the GPs had lead responsibility for safeguarding matters; however, one GP told us they could not remember when they last attended safeguarding training. The practice had a safeguarding statement, which noted procedures for staff to follow in order to raise an appropriate alert if they were concerned for a child or vulnerable adult.

The practice nurse had completed an online, e-learning module dealing with arrangements under the Mental Capacity Act (2005) and Safeguarding. The other staff at the practice told us they had also undertaken on-line safeguarding training and would report any initial concerns to one of the GPs.

We saw that the patient records system was 'flagged' appropriately to alert staff if safeguarding concerns had been identified for a particular patient. We also found that staff were aware of the requirements for children who were being looked after by the local authority.

Although the staff told us they had completed training, we noted that the practice did not have a formal record of which safeguarding training staff had undertaken, when it had occurred or how future safeguarding training needs had been identified. The practice may wish to review its safeguarding arrangements such as its policy, procedures and training in order to ensure it is able to respond appropriately to safeguarding incidents.

Monitoring Safety & Responding to Risk

There was an absence of formal written risk assessments across the practice. This included risks associated with dealing with emergencies and infection prevention and control.

There was not a robust system in place to record the way in which risk was assessed and mitigated across the practice.

Medicines Management

The practice had clear arrangements in place for issuing prescriptions and repeat prescriptions. We spoke with the staff who were responsible for processing prescriptions and they demonstrated an understanding of their role.

The emergency drugs checklist was intended to be reviewed every three months, however, we saw that these checks had not been signed and dated on every occasion..

Are services safe?

Cleanliness & Infection Control

One of the GPs was the lead for infection control. During our inspection we noted that the practice was visibly clean and tidy. Patients we spoke with told us they felt the waiting area was clean.

Staff had access to appropriate personal protective equipment such as gloves and aprons as required. The practice had a contract in place for professional sterilisation of medical equipment, with no 'single use' equipment being used.

We saw that appropriate arrangements were in place for clinical waste to be collected once a week by external contractors. We that the sharps boxes in consulting rooms in which sharp instruments were deposited had not been signed or dated in accordance with the Health & Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

We saw that the consulting rooms had privacy curtains made of fabric, rather than of a disposable material. One of the GPs told us that the curtains were washed regularly and that the carpets in the practice were steamed cleaned weekly. However, in both cases, the practice had no record of cleaning arrangements in place.

The practice had a cleaning policy which gave details of the arrangements in place for cleaning schedules and responsibilities. However, not all the checklists had been completed fully so the practice could not demonstrate if the policy had been followed and the infection risks reduced.

Staffing & Recruitment

The practice manager told us that staff levels were reviewed regularly, with staffing rotas created in advance based on the clinics which were running the following week. The practice made use of locum GP arrangements as required. Administration and reception staff were asked to help with additional cover for holidays or periods of absence caused by ill health as required.

Dealing with Emergencies

The practice had an agreement with a neighbourhood centre to temporarily use their facilities in order to provide services in the event of systems failures at the location. The practice had details of how to contact GPs in the event of their unplanned absence. Arrangements were in place with the out-of-hours service provider to respond to service demands when the practice was closed. The practice held regular fire alarm drills to test the understanding of the emergency procedure.

The practice had a programme to deal with the influenza vaccinations required at certain times of year. The practice told us that this involved staff at all levels and included the extended opening hours to promote the service and to encourage attendance.

We saw that the emergency medicines at the practice were in date and stored securely. We saw that keys required to access the emergency drugs container were kept in a locked cupboard located in the staff toilet. This meant there could be occasions, when the staff toilet was occupied, that a delay could occur if emergency medicines were required. We brought this to the attention of the practice as they had not considered this to be a risk and so had not assessed it as such. No changes to this arrangement were made on the day on the day of the inspection. We also saw that the emergency medicines were not stored safely as a variety of drugs were kept in the same small bugs which could, in an emergency, cause confusion and therefore pose a risk to patient safety.

The practice staff had access to an automated external defibrillator (an AED which is used to attempt to restart a person's heart in an emergency) and oxygen for use in a medical emergency. We asked members of staff who all knew the location of this equipment but there were no records to demonstrate that it was checked regularly.

Equipment

Non-emergency equipment was maintained and serviced by an external contractor and we saw records which confirmed that this took place at appropriate intervals. The practice manager told us that, as well as routine maintenance, the contractor could be contacted at any time to address any urgent issues with equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice was committed to improving services for patients. We saw, for example, the practice carried out a comprehensive influenza vaccination programme in line with current national requirements. Discussions with clinical staff confirmed that the practice had systems in place to ensure that current national and the local clinical commissioning group (CCG) recommendations and guidance was followed. For example, the practice had worked with the CCG pharmacist to review and check treatment for patients with osteoporosis, or who may be at risk of developing this condition. (Osteoporosis is a condition in which bone density is weakened and therefore can lead to brittle bones).

The practice managed patients with long term conditions by offering patients a review to assess, monitor and offer advice on how to manage their condition in line with the quality standards set out by the National Institute for Care and Health Excellence (NICE). For example, the practice had a register of patients with chronic long-term conditions who were invited to attend for an annual review of their health needs. Carers were also invited to attend to ensure that such assessments met the needs of the patients and those close to them.

We found that not all staff were aware of the Mental Capacity Act (2005). The practice should have a policy to help staff support people who might have limited mental capacity. We were not shown any evidence of a policy to support staff in assessing whether patients under 16 years of age could consent to treatment in their own right, a process known as the 'Gillick competence' test.

Management, monitoring and improving outcomes for people

The GPs were able to describe work undertaken at the practice relevant to the care offered to patients. The results were discussed and changes made where necessary. For example, as well as the review of patients with osteoporosis we also saw a similar review for patients who were called for retinal screening. This is a systematic, national screening programme that aims to reduce the risk of sight loss among people with diabetes through the early detection and appropriate treatment of sight problems associated with diabetes. The practice had a robust system in place and records we looked at showed an improvement in outcomes for patients.

Effective Staffing, equipment and facilities

Staff were provided with opportunities to learn and improve. They told us they were provided with enough opportunities for continuous learning which enabled them to retain their professional registration.

All staff told us their personal development was encouraged and supported, with training made available to keep knowledge and skills up-to-date. Protected time education took place on a regular basis. The practice provided placements for GPs to complete their training at the practice

Although the practice had not conducted a formal training needs analysis we saw that training was discussed as part of staff appraisals. Staff were trained and competent to carry out their role. We spoke with staff and the practice manager and looked at records. The practice had a staff induction policy and procedures in place.

The practice nurse was clinically supervised and appraised by one of the GPs. Administration and reception staff were appraised annually by the practice manager. The practice was supportive of staff who wished to attend training and continue their personal and professional learning and development. We saw that non-clinical staff were trained to enable them to be effective, this included basic training in safeguarding and health and safety. Staff told us their personal development needs and performance was discussed during their annual appraisal meeting.

The practice had a policy in place for managing poor or variable performance which focused on providing support and development as required.

All medical staff had undertaken the appraisal process in preparation for revalidation, the process by which GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

Working with other services

The practice had arrangements to work with other services as required. District nurses and health visitors attended the practice regularly. The district nurse told us they had a good working relationship with the GPs and the practice clinical staff which helped them in providing appropriate

Are services effective?

(for example, treatment is effective)

care to patients. For example, they told us that, as part of end of life care, they communicated with the GPs out of hours or at weekends and ensured continuity of care. Multi-disciplinary team meetings took place monthly where all members of the practice were invited. This included health visitors and palliative care nurses.

The practice also communicated daily with the out of hours service to determine if patients had been seen or were likely to require help or treatment out of hours. They told us that all urgent results were communicated to the practice by letter or telephone call to ensure that they were prioritised.

Health Promotion & Prevention

There was a range of information leaflets and posters in the reception area and throughout the practice regarding health promotion and prevention of ill health. Leaflets dealing with smoking cessation, depression and diabetes were amongst those available.

Patients in need of extra support were identified and their needs addressed. For example, patients who required end of life care were registered on the clinical system, had care plans and were discussed at regular clinical meetings to ensure their changing needs were met. Information was provided by the community nurses and palliative care service to ensure improved outcomes for patients through good communication.

Patients who had caring responsibilities were also identified on the clinical system and an alert was created to allow signposting to local support services to be offered where appropriate.

All new patients were offered routine health checks, where their medical history was taken. Where appropriate, patients were offered advice and support regarding lifestyle changes, exercise programmes, or weight control.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed that patients were treated with dignity and respect. This experience was confirmed by all of the patients we spoke with. Consultations took place in private with the doors to the treatment rooms being closed during such patient-doctor consultations. Privacy curtains were available in all the consultation rooms.

The practice had a chaperone policy. The staff who acted as chaperones had been trained and were aware of the policy and appropriate procedures. A sign advertising the chaperone policy was displayed in the waiting room area. We spoke with staff and they demonstrated how to offer patients the option of having a chaperone present during their consultation.

During the inspection we saw how the staff responded to patients and dealt with their questions and concerns. We saw that staff treated patients with kindness and respect and maintained their dignity. Staff members were helpful and sympathetic to patients experiencing discomfort on arrival and attempted to comfort them appropriately.

The general open-plan nature of the waiting area meant that, on occasions, it may be possible for personal information to be overheard from the reception window. However, we saw that staff were aware of this possibility and were discrete in their discussions with patients. The practice was able to make use of available office and consultation rooms should a patient ask for a discussion about sensitive matters.

Involvement in decisions and consent

All of the eight patients who spoke with us on the day of inspection told us they felt involved in making decisions about their care and treatment. This was supported by the comments we received from patients who had completed comment cards prior to our inspection.

Patients told us that they were provided with information regarding their treatment and had opportunity to ask questions. We saw that the practice had a policy regarding consent. Staff we spoke with told us that they always sought patients' consent and ensured their understanding before carrying out procedures. They confirmed that this was documented in patient notes where written consent was necessary. However, there were no policies on seeking consent from people who might have limited mental capacity or for assessing the competence of children under 16 to provide consent.

Respect, Dignity, Compassion & Empathy

Patients were provided with the support they need to cope emotionally with their care and treatment. We were told that the practice made appropriate referrals, for example to organisations that provided care and support to people who have been affected by a death or to help patients with mental health needs. Staff told us that families who had experienced bereavement could receive a follow up call to establish the need for support accordingly. In addition, counselling was available and patients were referred to this service as appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We spoke with the staff at the practice and found that they worked hard to understand the needs of their patients.

Following feedback they had received about the availability of appointments, the practice amended and extended its opening hours. This was to allow easier access to those groups of people who find it difficult to attend for appointments during the daytime hours.

The practice had a Patient Involvement Group (PIG), which met monthly. A Patient Involvement Group is a group of patients, registered with the surgery, who have an interest in the services provided. Such groups are also often known as Patient Participation Groups (PPG). The aim of the group is to represent patients' views and to work in partnership with the surgery to improve common understanding. A PPG can be an effective way for patients and GPs to work together to improve services and to promote health and improved quality of care.

We spoke with members of the Heatherbrook PIG who told us that the practice was responsive to the needs of patients. The group met regularly with minutes of the meetings made available on the notice board in the waiting room area. We saw that all newly registered patients were asked if they would like to join the PIG when they were registered with the practice.

The practice supported patients to receive a timely and accurate diagnosis, either directly from the practice or by referral to a specialist. Arrangements had been made which helped to ensure that test results were followed up in a timely manner.

The practice understood the needs of the different population groups it served. For example, The practice had a system to identify patients with learning disabilities. All such patients were offered an annual health check. The practice also maintained a note of carers in order to provide help, support and signposting to other support services as required. We also saw that the practice offered services to people with no fixed address by registering them as temporary residents. A GP we spoke with told us that people whose first language is not English normally chose to communicate using a family member or a friend. However, patients were offered the facility of a translator when required, which was arranged when necessary and co-ordinated with an appointment. There was some limited information about interpretation services displayed in the waiting room area.

Access to the service

The practice was open from 7.30am four days-a-week, with late night opening until 6.30pm also available four days-a-week. The patients we spoke with told us the availability of the GPs was good, with same-day appointments available. The practice offered patients different ways of accessing appointments. For example, patients were able to book appointments online, by telephone during surgery hours and in person at the surgery.

The practice also operated a telephone consultation system, for an initial triage service, telephone consultations and results service.

Patients told us that emergency or urgent appointments were always seen on the same day and were usually seen at the given time. When we inspected the practice we spent time at the reception desk and found that the appointment system worked well for the patients.

The practice leaflet provided information about the range of services offered and how patients could obtain medical support outside of surgery hours. Health promotion literature, and information about services at the practice, was available in the reception area and in other areas accessed by patients, for example outside the practice nurse's room. The practice website provided patients with information about opening hours, how to obtain repeat prescriptions, and what to do in an emergency.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person for handling complaints in the practice.

We saw that there was a complaints leaflet for patients. The leaflet had information about how to make a complaint, with details of the NHS England complaints team and the Parliamentary Health Services Ombudsman, should onward referral be required. The leaflet was available to patients in the reception area. A comments box was also available in the reception area for patients to leave their views about the service.

Are services responsive to people's needs?

(for example, to feedback?)

We saw examples of some of the complaints and comments from patients and the response from the practice. Complaints were dealt with in accordance with the policy and procedures. The practice complaints policy included actions to ensure complaints were dealt with in a timely fashion. The outcomes of complaints were discussed at staff and practice meetings.

Are services well-led?

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

Our findings

Leadership & Culture

The practice had an open and transparent leadership culture and a philosophy of patient care that was shared by all staff. The practice manager and staff told us that the all staff practice meetings were open for discussion and provided support and guidance for staff about all aspects of their work. We saw minutes from the staff meetings which showed how matters were raised and discussed. Outside of a formal meetings structure, staff told us they would talk with one of the GPs if they were unsure about anything.

The practice had a statement of purpose, which set out clear aims and objectives for delivering services. It contained a description of the range of services offered, including partnership working with other professionals to deliver care and ensure a better experience and improved outcomes for patients.

Governance Arrangements

The two GPs worked to maintain an open and inclusive culture. The practice actively sought feedback from patients via the Patient Involvement Group (PIG), annual patient surveys and from the staff during appraisals. Patient involvement (or participation) groups are drawn from patients at GP practices, formed with the objective of working in partnership with GPs to improve services. Staff involvement was also encouraged in improving the services provided to patients.

Staff were aware of their responsibilities within their role and were able to explain who they would go to should they have concerns regarding any issues arising within the practice.

Systems to monitor and improve quality & improvement (leadership)

We saw that patients' complaints were reviewed and findings reported to practice staff. The results of a patients' survey, had also been analysed and the outcomes were to be published in the newsletter and displayed on the notice board.

The practice did not have robust arrangements for identifying, recording and managing risks. For example there was not a culture of written risk assessment across all areas of the practice. There was no robust system to monitor infection prevention and control in order to protect patients from the associated risks. Checks of emergency medicines and equipment were not implemented well enough to ensure patients were kept safe.

Patient Experience & Involvement & Practice seeks and acts on feedback from users, public and staff

We received positive feedback from the patients we spoke with. They told us that they felt involved with their care and that staff at the practice listened to their needs and concerns.

The practice made use of the Practice Involvement Group (PIG), with the chair of the PIG involved in the design and analysis of the patients' survey. The practice also made use of feedback received from the comments box in reception to understand the views of patients.

We saw evidence of where the practice had taken steps to review services and undertake action to improve the patient experience, particularly in respect of the appointments system and expansion of opening hours. Comments were fed into practice meetings and any outcomes were communicated to staff and actions undertaken or referred to practice team meetings to discuss future actions.

The staff were aware of the whistleblowing policy, which contained information to support staff with allocated staff members identified to whom concerned could be addressed.

Management lead through learning & improvement

The practice had an ethos of supporting the staff learning and development process, with training and on going support and appraisal. We saw evidence of staff appraisal and staff we spoke with confirmed that they had an opportunity to express their own learning and development needs through the process.

Identification & Management of Risk

The practice did not have formal risk management policy or checks in place. However, staff demonstrated an awareness of what they would do in the event of an adverse situation, with health and safety, safeguarding and whistleblowing examples identified.

Older people

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

Our findings

The practice provided care for the older population in their own homes and for those who lived in residential homes. The practice provided proactive home visits and responsive visits where appropriate. Patients who were unable to attend the surgery received visits from the GPs when needed, for example, to provide routine flu vaccinations. All patients over 75 years of age had a named GP to help achieve continuity of care and reduce risks to patients. The practice took additional steps to target older people and they were offered additional relevant health checks when appropriate.

People with long term conditions

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

Our findings

The practice managed patients with long term conditions by offering patients a review to assess, monitor and offer advice on how to manage their condition. The practice had a register of patients with chronic long-term conditions. Patients on the register were invited to attend for an annual review of their health needs. Carers were also invited to attend. Patients with unplanned hospital admissions were reviewed to identify possible gaps in treatment or opportunities for improving the understanding of the treatment or education regarding self-management of the condition.

Mothers, babies, children and young people

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

Our findings

The practice provided care to new born children, with six-week examination and childhood immunisations provided in line with national recommendations. We saw that the practice was supportive of the needs of mothers and offered immediate access to a doctor in the event of a suspected child illness. The practice offered advice from midwives and health visitors. Services available included pregnancy and family planning and the insertion and removal of contraceptive implants and coils. The practice also offered smoking cessation advice, with support and literature available.

Working age people (and those recently retired)

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

Our findings

The practice offered extended opening hours four days a week with early morning opening at 7.30am and later closing at 6.30pm. On three days of the week the practice also provided telephone consultations until 8.00pm for those people working and unable to attend for appointment during the normal hours of a working day.

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

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

Our findings

The practice had a system to identify patients with learning disabilities. All patients were offered an annual health check. The practice also maintained a note of carers in order to provide help, support and signposting to other support services as required. The practice offered services to people with no fixed address by registering them as temporary residents. Referral to secondary services, such as maternity services were made as required.

People experiencing poor mental health

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

Our findings

The practice was able to identify patients with mental health conditions and offered information and support as appropriate. The practice had links with specialist agencies and other services to deliver good coordination of care including referrals to those services when patients needed more specialised care.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The practice did not have effective systems in place for assessing the risks associated with providing the regulated activities. The practice did not have an effective system in place to monitor the quality of service provided.**