Concord 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.

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Summary of findings

Overall summary

Concord Medical Centre is situated in Little Stoke, South Gloucestershire. The practice serves approximately 14,000 patients. The services provided include, child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions and smoking cessation clinics. Additional services included scanning for osteoporosis, ear nose and throat (ENT) procedures including mircosuction specifically for cleaning of the ears and a full time mental health nurse consultant.

During our inspection, we spoke with 12 patients. All of the patients spoken with on the day were very positive about the service provided with a collective view that patients were at the centre of the practices service delivery.

There were systems in place to ensure effective patient care and we heard about a high level of patient satisfaction with the care and treatment provided. Patients were treated with dignity and respect in a purpose built environment which was accessible and ensured their privacy. The appointment system enabled patients to be seen quickly and for the amount of time their needs required. The practice was responsive to the needs of the patient and continuously strived to improve the service it provided through active engagement with the patient group. The practice was well led by the practice manager and their partner GPs. They were supported by a practice nursing and staff team.

The practice must protect patients against the risks associated with the unsafe management of medicines, by making appropriate arrangements for the recording, safe keeping and disposal of medicines.

Patients over the age of 75 had been allocated a dedicated GP to oversee their individual care and treatment requirements delivered in the practice or in the patients own home.

Mothers, babies, children and young people had access to dedicated specialised staff as well as dedicated practice clinics, such as child immunisations.

The practice made provision for the working-age population and those recently retired with some additional early morning and evening appointments and alternate Saturday clinics as well as telephone consultations.

Patients in vulnerable circumstances who may have poor access to primary care were also provided with services by the practice.

Patients experiencing poor mental health had access to a practice mental health nurse consultant who provided additional therapies and support.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found the practice had safe arrangements in place to report and record incidents and staff understood their role and accountability in reporting incidents.

The practice learnt when things went wrong and actively sought to improve the service to ensure patients received good quality care.

The practice had comprehensive policies and procedures in place to keep patients safe and staff were aware of their responsibilities in regard of the management of practices such as, infection control, safeguarding vulnerable patients and safe use of equipment. However, a breach of regulation was identified for the practice to ensure patients were protected from the risks associated with how they managed medicines.

Staffing levels and skills mix were assessed regularly to ensure access to appointments and patient safety. There were plans in place to deal with medical emergencies.

There were systems in place to ensure the practice could efficiently deal with any foreseeable emergency.

Are services effective?

Patients received care and treatment that was delivered in line with the latest national standards, such as monitoring the alerts provided from the Medicines and Healthcare Products Regulatory Agency (MHRA).

The practice regularly monitored positive outcomes for patients and compared them to others, including undertaking clinical audits and holding regular meeting with other professionals.

The practice had staffing, equipment and facilities which enabled an effective delivery of care.

The practice supported and enabled regular multidisciplinary working with other services that ensured the best possible care was provided to its patients.

The practice supported patients who required health promotion and preventative care.

Are services caring?

Staff treated patients with kindness, dignity, respect, compassion and empathy.

Summary of findings

Patients understood their treatment and were involved in decision making about their care and treatment.

Patients could involve their partners or carers when they chose. Staff demonstrated a clear understanding of consent and decisions made in the patients best interest.

Patients were provided with emotional support when they needed it and were signposted to other support networks if required.

Are services responsive to people's needs?

The practice planned and delivered services to meet the needs of different patients.

The practice had an appointment system that enabled them to provide care and treatment at the right time for patients.

Patients needs and wishes were understood by staff and influenced care and treatment through referrals to secondary health care.

Patients concerns and complaints were listened to and acted upon to improve the service overall.

Are services well-led?

The practice had a clear vision and strategy to deliver high quality care.

The practice governance arrangements provided clear decision making and engagement with others.

The leadership and culture of the practice reflected a supported and motivated staff team and an open and transparent team working environment.

The practice sought the views of patients and acted on feedback from patients and staff.

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 operated a system where patients who were 75 years and above were allocated a named GP, which was in line with national General Medical Service contract. Those patients were given priority to see their allocated GP and if this was not possible then they were allocated a secondary GP to ensure further consistency of care.

The GPs conducted home visits for older patients and those were unable to get to the practice. The practice had undertaken recent work to identify and assist patients who had caring responsibilities for older people and were developing a new carers group.

There were monthly meetings with a multidisciplinary team consisting of community district nurses, the practice mental health nurse consultant and the palliative care team to discuss and meet the needs of patients with complex health care needs.

People with long-term conditions

Patients with long term conditions were well supported to manage their health, care and treatment. They benefitted from effective information and guidance from the practice about the management of their conditions. The practice offered a range of clinics during the week run by specially trained nurses for patients with long term health conditions, such as diabetes and respiratory conditions.

Mothers, babies, children and young people

The practice had a variety of clinics to assist mothers, babies and young children. Staff worked closely with the local health visitors and community midwives to identify children who were at risk and ensured they received appropriate care and treatment. Parents we spoke with told us the staff had good communication skills and were good at explaining care and treatment options to younger patients.

The working-age population and those recently retired

The practice provided a variety of ways working aged patients and those recently retired could contact the practice, so they could access primary medical services. These included evening appointments, on-line appointment booking, telephone consultations and Saturday clinics.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care Staff had developed links with patients in vulnerable circumstances. They provided a service to patients residing in a protective environment. The practice had a system which ensured patients with a learning disability were identified and received an annual health check. They also monitored patients who suffered from domestic violence to ensure they were provided with additional support where necessary.	
People experiencing poor mental health The practice had recognised the need to support patients with mental health needs. They employed a full-time mental health nurse consultant, who worked closely with patients and the GP team. They provided essential support to patients with a diagnosed mental health problem. The practice held monthly multidisciplinary meetings with other professionals, which ensured a consistent care package was provided to these patients.	

Summary of findings

What people who use the service say

During our inspection we spoke with 12 patients who told us they were very happy with the service received. Patients told us they were confident in the GPs advice and decision making about their care and treatment. They explained they could usually see the same GP and always had enough time to talk about their problems without feeling rushed.

The practice was developing a patient involvement group to gain views from patients and involve them in how the practice was run and to improve services. The practice manager told us the average age of the patients registered at the practice was 38 years old with the majority of the group made up of working age adults and younger families. Their aim was to encourage participation from a number of patients from these population groups. To do this the practice had started to develop a virtual patient group and aimed to gain patient views through email correspondence. They currently had 70 members signed up with an intention to sign up a total of 100 patients.

The practice completed an annual patient satisfaction survey. The last one had been completed for the year 2013-2014. This showed an 87% satisfaction rate for all aspects of the service from the 485 patients surveyed. The survey showed the least satisfactory area of the services provided was the telephone appointment system. Since the survey the practice had implemented a new appointment system. They anticipated patient satisfaction would be increased in the next survey.

We reviewed other sources of what patient experienced with the service provided prior to our inspection. This included NHS Choices (a forum for patients to provide their views about the service publicly and where the practice responds to their views). We saw patients had made five comments in the last year. Three out of five comments provided a five star rating (the highest satisfaction level) of the service provided. Two out of five comments gave the practice a one star rating. The practice had responded to both of these comments and had asked the patients to contact the practice. The two patients were mainly not satisfied with the communication with staff and having been unable to book pre-bookable appointments. We also reviewed the national GP survey results from January to March 2013 and July to September 2013 (this is a national survey sent to patients by an independent company on behalf of NHS England). One hundred and twenty-four patients completed the survey and this showed areas for improvement, such as ease of access on the telephone and level of privacy in the reception area. We saw the practice had made or was in process of completing improvements to the service to improve patient satisfaction in these areas.

Areas for improvement

Action the service MUST take to improve

- The practice must ensure controlled drugs are held securely, accounted for when used and disposed of in line with national guidance. The practice must ensure other medicines are held securely.

Action the service SHOULD take to improve

- Patients should be informed by the provider what improvements they intended to take following a patient satisfaction survey.
- The practice should ensure policies related to safeguarding vulnerable patients should include contact numbers for referrals to external authorities to ensure prompt action was taken where abuse concerns arise.

Summary of findings

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice had invested in a bone density scanner for its patients and the public. The scanner is used to diagnose osteoporosis (reduced bone density) or for athletes to improve their fitness programme. We were told by one of the GPs that only one or two other surgeries in the country had a scanner of this type to help diagnose osteoporosis in a practice setting. Normally patients would have to be referred to hospital for this diagnosis. They had also scanned 150 patients for the local hospital which helped reduce patient waiting times to be seen in hospital.

The practice provided an ear, nose and throat (ENT) service to its patients and the public. This included treatments such as microsuction (ear wax and other debris removal technique which allowed treatment for patients who cannot have their ear syringed in the usual way). Normally patients are referred to hospital for this treatment.

The practice provided another additional service called dermoscopy (this helps to identify benign lesions as part of the early diagnosis of skin cancers which could help to reduce referrals to hospital). This improved early diagnosis for patients and helped reduce waiting times at hospitals.

The practice had developed an integrated service provision with the Bristol Oncology Centre hospital staff to provide in house oncology treatment, a branch of medicine which deals with cancer, for patients within the community.

The practice employed a full-time mental health nurse consultant. With qualifications in cognitive behaviour therapy, psychiatric nursing and community mental health nursing.

The practice had specialist expertise in treating and caring for vulnerable patients from different cultural and background circumstances.

The practice offered development opportunities to staff that could benefit patients. A receptionist/health care assistant had been trained in British Sign Language. This enabled them to support patients who used this language.

The practice had been accredited with the Royal College of General Practitioners quality practice award. This was awarded in recognition of how they improved patient quality care and outcomes, and had demonstrated good practice and organisational and clinical excellence in their practice.

The practice is involved in a programme called 'productive general practice' supported by the NHS Improving Quality. One of the GPs led on this and they told us the programme sought to provide better care through a structured whole practice approach. So far the practice had achieved this by empowering members of the administration team, such as dealing with safeguarding correspondence with the GP having the overall responsibility.

Concord Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor, a CQC pharmacist, a specialist advisor to review the practice management and an expert by experience. Experts by experience are a part of the inspection team and are granted the same authority to enter registered providers premises as the CQC inspectors. The GP specialist advisor had experience both as a GP and as a clinical director for a number of medical services. The specialist advisor who reviewed the practice management had a number of years of experience in governance and operations for an Out of Hour's provider. The expert by experience had experience as a patient using medical community services.

Background to Concord Medical Centre

Concord Medical Centre provided primary care to approximately14,000 patients. The practice is based in an area which had a predominantly working-age population with a high number of families. The national general practice profile stated they had a lower than average over 75 year old age range with 6% of patients over the age of 75 compared to a 9.9% England average. There was a small minority of ethnic minorities registered at the practice which included 2.6% of patients declaring they were from an Asian ethnic group and 2.6% of patients stating they were from non-white ethnic groups.

The practice employed 10 GPs, six partners and four salaried GPs. In addition the practice had a mental health nurse consultant who supported patients experiencing mental health issues. There were also three locum doctors and two trainee GPs providing care and treatment. A team of five practice nurses, eight health care assistants, a phlebotomist (takes blood samples) and 18 administration/reception staff, were also employed by the practice. During our inspection we spoke with 13 members of the practice team including five GPs, one practice nurse and three health care assistants.

The practice provided training to qualified doctors, who wished to continue their training into general practice. The practice provided training for six to 12 months for these practitioners to gain GP experience. The practice had two GP trainees at the time of the inspection. The practice participated in research projects to improve general practice.

The practice was purpose built and had facilities to meet the needs of its patients with disabilities. The practice referred patients to another provider for an Out of Hours service to deal with any urgent needs when the practice was closed.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before we inspected the practice, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the South Gloucestershire Clinical Commissioning Group, NHS England, South Gloucestershire Healthwatch and Avon Local Medical Council. We carried out an announced visit on Monday 4 August 2014. During our visit we spoke with a range of staff including GPs, practice nurses, health care assistants and administration staff. We also spoke with patients. We observed in communal areas how patients were being spoken with and we talked with carers and/or family members.

Are services safe?

Our findings

Safe track record

There were effective arrangements in place to report safety incidents in line with national and statutory guidance. Staff we spoke with knew their role and accountability in reporting incidents. For example, one member of staff told us they were concerned about a vulnerable adult. They reported this to the GP and the GP visited the patient and reported the concerns to local safeguarding authority. Another member of staff told us what action they would take in respect of a needle injury and how to report this to the relevant authorities. Staff were aware of management lines of responsibility of who to report to, this ensured incidents were accounted for.

Incident forms were available on the practice intranet site. All staff sent completed incident forms to the practice manager, to enable them to monitor and manage incidents in the practice.

Learning and improvements from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw the practice had a significant events register where all events were triaged with a risk level, areas of concern identified and actions taken to address these areas of concern. The practice had six significant events in the last six months. GPs we spoke with told us of significant events that had been identified. For example, a request for a patient to have a clinical review had been written on a note accompanying a prescription for the patient which had then been sent to the pharmacy. The patient felt upset that a disclosure about their condition had therefore been made. The practice dealt with their concerns sensitively and protocols had been amended to reduce this from happening again. We saw GPs discussed learning from significant events at their weekly clinical meetings. They told us they would involve other staff members, such as the administration team, if concerns related to this area.

The practice manager told our accompanying specialist advisor who reviewed practice management that since there had been a child death enquiry, the practice had made improvements to their system. This included all letters related to children who attended accident and emergency departments were now screened by one of two trained administrators. If it was determined significant then the letter would be passed on to the child safeguarding GP lead to review and take action where necessary. The practice also monitored Out of Hours reports related to children and when children did not attend appointments.

Reliable safety systems and processes including safeguarding

There were reliable systems in place which ensured patients were safeguarded from the risk of abuse. The practice had ensured all staff were trained in protecting vulnerable adults and children from abuse. Staff, including GPs and nurse practitioners were level 3 trained in child protection annually. The training was provided by the local South Gloucestershire Clinical Commissioning Group. The practice had assessed that selected administration staff that dealt with any safeguarding information were level 2 trained and all other staff were level 1 trained. Staff completed e-learning training in protecting vulnerable adults.

All the staff we spoke with demonstrated a clear understanding of the types of abuse which might occur as well as the signs and symptoms of abuse. Staff told us they understood their responsibilities and what action they should take if abuse was suspected. The practice had policies for child protection and at risk adults, these included detailed information on how to recognise abuse and what action to take. We saw these policies did not include contact numbers for referrals to external authorities. Although the staff we spoke with knew who and how to contact these services.

Patients we spoke with told us they felt safe in the practice and that their care and support was delivered by competent and professional staff. The practice had a chaperoning policy and service available to all patients which ensured patients who received intimate treatment had the opportunity to see a GP or nurse accompanied by a skilled and knowledgeable chaperone.

There were a number of children known to the practice on the child protection register. The practice also held a vulnerable family register. This included families where an individual may have a social, drug, alcohol or learning difficulties as well as children at risk. The GP with lead responsibility for child protection held a monthly meeting with the multidisciplinary team which included a health visitor. This was an opportunity to discuss children at risk and have a coordinated approach with other professionals that enabled protection plans to be implemented

effectively. The practice discussed adults at risk monthly with a multidisciplinary team, which included emergency care practitioners, district nurses, palliative care nurses and social workers. This ensured a co-ordinated and consistent response to these patients needs.

We spoke with an administrator who had the responsibility of dealing with incoming safeguarding correspondence, such as police reports related to at risk children or domestic violence. They told us they allocated the reports to the appropriate GP for review and added any alerts onto the patient record system. This ensured patients at risk would be identified by staff when these patients contacted the practice. The practice also ensured the Out of Hours system reflected any risks identified to ensure the Out of Hour's service was aware of the concerns in relation to vulnerable patients.

Monitoring Safety and Responding to Risk

We saw that staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. For example, more GPs were available to see patients on a Monday, which was the busiest day for the practice. Practice nurses were similarly flexibly available and there was always at least one practice nurse who worked alongside the GPs during opening hours.

Administration staff who booked patient appointments had access to information about each member of the GPs and nursing staff's specialities. This ensured patients were booked in with the most appropriate person. For example, GPs were specified who were trained to fit contraceptive coils or carry out steroid injections. Nurses were identified who had been trained in areas such as cervical smears or immunisations.

The practice manager had a system for monitoring annual leave which ensured staffing levels were kept stable. They told us they had a system in place to ensure staff were multi-skilled and could cover for sickness or annual leave. For example, each treatment the nursing staff provided there was an additional member who was also trained in it, such as asthma or chronic obstructive pulmonary disease (COPD) checks. If GPs were on annual leave then other GPs would cover patients test results, hospital letters and Out Of Hours reports. This approach ensured anything urgent was not missed.

Medicines management

We looked at all the areas in the practice where medicines were stored and the records relating to this. We also spoke to staff and looked at the arrangements in place for patients to order repeat prescriptions.

Safe systems were in place for patients to order repeat prescriptions. A detailed prescribing protocol was in place. This highlighted the checks needed for the safe use of some medicines, such as blood tests. Staff made sure these had been completed before they issued the repeat prescriptions. This helped ensure patients were safe when taking their medicines. Patients could collect their medicines from their own choice of pharmacy and did not have to attend the practice to collect the prescription first.

The practice stored vaccines and other medicines requiring refrigeration in dedicated medicines refrigerators. Daily records of the temperature of the refrigerators showed these were suitable for the safe storage of medicines.

Staff made regular checks of the expiry dates of the medicines kept to make sure the medicines were safe to use. A supply of emergency medicines and equipment was available. Records showed staff checked these regularly, to make sure they were suitable for use.

A small supply of Controlled Drugs was kept for emergency use. This group of medicines need additional security. Records of these medicines had not always been completed fully. For example, one patient had received a controlled drug however, no personal details were completed in the controlled drugs register. We also found two out of date controlled drugs. These had been labelled as found in a surgery room but there was no date of when they were found or who had them. There was no record of these in the controlled drugs register.

Emergency medicines were not always kept secure. The emergency medicines trolley was kept in a communal corridor. This trolley had the facility to be secured. However at the time of our inspection the trolley was not secured. This meant patients could access the medicines kept in this trolley.

Other medicines used for routine treatment in the practice were not stored securely. At least ten different types of medicines were kept in cupboards that had no locks and

were kept in an unlocked room. Controlled drugs were kept in an appropriate double locked cupboard. However, the key was not held securely and access to it was not monitored.

Cleanliness and infection control

Patients were treated in a clean, hygienic environment. All communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor. Three cleaners were employed and were given designated areas of the practice to clean. The practice had its own sluice for the disposal of bodily fluids. We saw throughout the inspection that areas of the practice were clean, tidy and free of items which may cause cross infection. An audit in May 2014 identified there were issues in respect of cleanliness. We found evidence of dust around the piping and grubby floor areas in two toilets (one used for staff only). We were informed by the practice manager that cleaning staff had been spoken with at the time. However, we saw this still had not been improved.

Clinical areas of the surgeries had designated clinical spaces with surfaces which could be wiped clean. Appropriate personal protective equipment such as examination gloves and plastic protective aprons were available in these areas and were stored appropriately. Nursing staff told us of procedures followed to dispose of clinical waste and sharp objects such as injection needles. Sharp objects were disposed of in three separate, clearly marked bins which ensured the correct disposal of the items. Clinical waste was stored in a secure area outside until it was collected by official waste collectors.

The lead practice nurse had the responsibility for ensuring there was effective infection control throughout the practice. The lead nurse attended external annual training on infection control and participated in a forum for South Gloucestershire nurses, which took place quarterly. From this learning the nurse cascaded the training to GPs, nurses and health care assistants. The lead nurse had completed an infection control audit in April 2014. We were told audits were carried out quarterly by the lead nurse. Some areas for improvement had been identified such as sharps bins not to be kept on the floor in surgery rooms and not to fill sharps bins over their capacity level. Staff told us they were reminded of the practice protocols. However, we observed during our inspection that a sharps bin had been left on the floor in a surgery room. We also found there was no identified action plan following the infection control audit of when the identified actions would be completed or who was responsible for the tasks.

Good hand hygiene principles were encouraged by the practice. Hand hygiene techniques signage was displayed in patient and staff toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Reminders were sent to staff about hand hygiene principles and practice.

All GP, healthcare and nursing staff we spoke with knew how to deal with an infectious disease outbreak and which authorities they needed to report to. There had been no outbreaks of infectious diseases or viruses at the practice.

Staffing and Recruitment

The practice had relevant recruitment procedures in place that ensured staff were recruited appropriately. The majority of staff had been employed by the practice for more than five years. The practice manager told us staff were recruited through an application process which gained information about their employment history and identified any gaps in employment. They told us gaps in employment were part of the recruitment process and were clarified with the applicant. References were taken from previous employers, where possible and staff were interviewed for the role before they were offered the post.

Before staff were appointed there was evidence that relevant checks had been made in relation to registration with their professional body. Criminal background checks undertaken by the Disclosure and Barring Service (DBS) had been made for all staff. The practice manager told us that proof of identification of prospective staff had been taken because it had been required for criminal background checks but had since disposed of it. They told us they would ensure proof of identification was kept as part of their recruitment process for all new employees.

All staff went through a practice induction before they started their role. We saw a trainee GP induction programme which covered a welcome to the practice by a GP partner, health and safety protocols, human resources protocols, prescribing, IT system, tutorials with other GPs, specialist areas such as child health and immunisations. This demonstrated that new staff were safely orientated to the practice and were made aware of key policies and procedures.

Are services safe?

Dealing with Emergencies

The practice had a proactive approach to anticipating potential patient safety risks in regard to emergency situations. The practice had a business continuity policy which described to staff what to do in an event of an emergency. It covered areas such as a viral epidemic, closure of the premises or IT failure. If the practice had to close urgently then they had an agreement with other nearby practices for patients to be seen by them if in urgent need. If there was an electrical fault which caused a computer system failure then the practice had contact numbers for staff to contact. GPs would make phone calls from home or mobile telephones to reach patients in need. The practice manager told us of one occasion when there had been a significant amount of snow. To manage this emergency the practice took the decision to phone patients rather than see them in the practice to reduce the risk of patients slipping and requiring hospital treatment on their way to the practice.

There were sufficient systems in place to deal with a medical emergency. The practice had an automated external defibrillator and emergency medicines. Routine checks of this equipment were undertaken monthly by an allocated nursing staff member. Staff told us they felt confident to deal with a medical emergency. We saw GP, nursing and healthcare staff had regular annual cardiopulmonary resuscitation training. All other staff received training every three years for cardiopulmonary resuscitation. The practice manager told us they were in the process of reviewing this and may decide to implement the same annual training for administration staff as GPs, healthcare and nursing staff received.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients care and treatment needs were assessed and care and treatment were delivered in line with current legislation, standards and guidance. GPs had access to clinical guidance through an IT computer based learning system. This was a practice based repository accessible to staff on guidance on clinical practice. Any guidance updates found by colleagues were shared with other GPs. We were told of an example where a GP had read guidance on medicines that can help lower the level of low-density lipoprotein (LDL) cholesterol in the blood and summarised it for other GPs to read.

The practice was involved in a programme called 'productive general practice' supported by the NHS Improving Quality. One of the GPs led on this and they told us the programme sought to provide better care through a structured whole practice approach. So far the practice had achieved this by empowering members of the administration team, such as dealing with safeguarding correspondence with the GP having the overall responsibility.

One of the GP partners told us the practice regularly reviewed the latest Medicines and Healthcare Products Regulatory Agency (MHRA) alerts which ensured effective treatment of patients. The lead GP for updating other staff worked with a dedicated administrator and Clinical Commissioning Group medicines lead practitioner to agree actions following updates. This included the content of communication provided to patients.

Patients capacity to consent was assessed in line with the Mental Capacity Act 2005 (MCA) and Gillick competence framework. The MCA is a framework which supports adults who need help to make decisions. The Gillick competence framework supports children who wish to make a decision without their parent or guardian present. Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. The GPs we spoke with demonstrated a clear understanding of the Gillick competency guidance and worked with younger patients to ensure they understood relevant issues such as sexual health.

Management, monitoring and improving outcomes for people

The practice manager and GPs told our specialist GP advisor that clinical audits were completed by GP and nursing staff and kept in a central repository for other GPs to refer to. One of the GP partners told us they had recognised this was an area for improvement because it had not been well used by GPs and nursing staff.

GPs we spoke with told our accompanying GP specialist advisor what clinical audits which were being undertaken. One GP told us they were completing a deep vein thrombosis (DVT) audit. This was because they had received feedback from the local DVT ultrasound service to advise they may have been referring patients who did not meet the referral criteria. An audit had been completed to identify if this was the case, the results of this audit were not yet fully compiled.

The practice received an award for identifying patients who were at risk of atrial fibrillation and required anticoagulants (medicines to reduce blood clots). GPs who completed this clinical exercise told us they found it educational in terms of improving practice. They were now in the process of using this information to inform and educate patients with this diagnosis.

GPs had received dementia awareness training through the Clinical Commissioning Group. We were told the practice had a protocol for assessment for dementia before they were referred to a memory service for further diagnosis.

The practice had developed an integrated service provision with the Bristol Oncology Centre hospital staff to provide in house oncology treatment, a branch of medicine which deals with cancer, for patients within the community. Patients were seen in the upgraded treatment suite and there was an outside community garden for patients to use during treatment. The local garden centre had donated plants for the new community garden.

Effective staffing, equipment and facilities

Each GP ensured they developed their knowledge and skills through a continuous professional development pathway. The GPs reviewed their professional development with their appraiser during annual GP appraisal which supported their revalidation. Associate GPs we spoke with told us they were appraised annually by a GP partner.

Nurse practitioners and health care assistants were all appraised by the practice manager and the lead GP for

Are services effective?

(for example, treatment is effective)

appraisals. Appraisals reviewed any training or professional development and set goals and objectives for the year. These were completed annually with a six month review to update on whether objectives were being met.

Staff told us about development opportunities provided by the practice. One member of staff had started as a receptionist and had been trained in other areas of the practice, such as complex administration work, phlebotomy (taking blood samples) and was in process of completing training as a health care assistant.

Staff told us they had received training in particular areas such as safeguarding children and cardiopulmonary resuscitation (CPR). We were also informed that infection control training was cascaded to staff through the lead nurse, who completed annual training. However, there was no system in place to monitor the staffing group's mandatory training. For example, if members of staff had missed a training day due to annual leave or sickness. Training certificates were kept in individual staff files however this information was not collated by the practice manager. The practice manager was unable to demonstrate that all staff were trained at the correct intervals for their mandatory training.

Staff told us they had the equipment necessary to carry out their role effectively. The practice nurse told us equipment, such as ECG machines, blood pressure monitors, spirometry and weighting machines were calibrated every six months.

The practice had invested in a bone density scanner for its patients and the public. The scanner is used to diagnose osteoporosis (reduced bone density) or for athletes to improve their fitness programme. We were told by one of the GPs that only one or two other surgeries in the country had a scanner of this type to help diagnose osteoporosis in a practice setting. Normally patients would have to be referred to hospital for this diagnosis. They had also scanned 150 patients for the local hospital which helped reduce patient waiting times to be seen in hospital.

We saw patient records were kept confidential because they were stored in an administration room that was secured by a key coded security pad. However, we saw patients test samples, that included patients confidential information, were kept in the practice sluice room, before they were collected for testing. We saw the sluice room door was routinely kept open and there was no lock on the door to keep the room secure. This meant that patients confidential information was subject to unauthorised access. We informed the practice manager of this shortly after our inspection and they told us that test samples should not be kept in this room and they would remind staff that these should be kept in the secure reception area.

Working with other services

The practice worked alongside the local hospitals and community services to help reduce secondary care referrals. The practice had a number of additional services that enabled them to see their own patients for secondary care aspects because they provided the service in-house. For example, scanning patients for diagnosing osteoporosis, some ear nose and throat procedures and some skin lesion screening was available. The practice had also assisted the hospital to reduce waiting times for people in the local area who were waiting for scanning following a hospital referral.

The practice nurse told us they often gained advice from community services if they had complex treatments to provide. For example, a patient required a dressing for a complex condition. They arranged for the district nurses to visit and assist them with a care plan to manage the patient safely. The lead nurse was now liaising with the district nursing team to arrange regular training in wound management.

The practice held multidisciplinary monthly meetings with other health care professionals, such as district nurses, mental health nurse consultant, palliative care nurses, health visitors and midwifes. This enabled the GPs and nursing staff to discuss patients with complex health problems and adults and children at risk. This approach helped to improve a coordinated approach to enable patients to receive appropriate care and treatment.

The practice worked with other practices in the South of England, who were part of the quality practice network. This was a forum where likeminded practices could share best practice and policy documentation for shared learning.

The practice shared patient information with the Out of Hours service through 'special messages' for patients who were at risk of being admitted to hospital or if they anticipated an abnormal blood test result. Out Of Hours

Are services effective?

(for example, treatment is effective)

information received by the practice was triaged and if it was triaged as urgent then the duty GP would assess and deal with the information received. Otherwise non-urgent information would be dealt with by the patients GP.

Health, promotion and prevention

All new patients were encouraged to make an appointment for a consultation with a GP when they registered with the practice. The practice asked patients to complete a new registration form and a patient questionnaire, which included information about their lifestyle and social factors. This enabled the GP to focus on particular areas of health concern when they saw them for their first appointment.

Patients were able to attend special clinics on smoking cessation led by staff that had been specifically trained in these areas. One staff member we spoke with who took part in these clinics told us they were well used by patients and had received positive feedback from patients. Within these clinics we were told health checks were carried out on patients who requested them.

One of the GP partners told our accompanying GP that they used the influenza clinics to support and educate patients. They had invited representatives of Age Concern to the practice so they could speak with patients and provided advice to patients who may also be carers. Patients were also offered any outstanding health checks required and offered additional vaccines, such as shingles and the pneumococcal vaccine.

All GPs and nursing staff and call handlers encouraged patients, who either attended the practice for an appointment or phoned the practice, to attend the practice for health checks if they were due. Overdue health checks were flagged on the system so staff could identify patients for health checks.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice was purpose built and had facilities which enabled all patients to easily access the building. This included facilities for patients with disabilities and a hearing loop available for patients who were hard of hearing in the reception area. A member of administration staff had been trained in British Sign Language, which enabled them to support patients who were deaf.

The practice used an interpretation service which was available for patients who did not have English as their first language. A number of GPs were multilingual and so patients could opt to see them or they could assist with consultations when necessary. The touch screen log in system for patients to confirm they had arrived for their appointment was also available in other languages, such as Polish.

The reception area was set away from the waiting areas in the practice. The reception point had three desks and one had been partly partitioned to aid with confidentiality. This area was not sound proof and other patients could still hear conversations between the receptionist and patient. The practice had recognised this and had decided to upgrade this area to include sound proofing and an extended partition to aid further confidentiality. We observed there was no lowered reception desk for ease of access for wheelchair users and children.

The patients we spoke with told us they were happy with the treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We observed receptionists showing respect and care when dealing with patient queries at the reception desk.

The practice manager told us patients who had recently suffered loss of a loved one were supported by the practice. GPs would contact the patient to identify if they wanted any additional support. The practice would also send patients a condolence card, so they knew the practice was there to support them if needed. Administration staff ensured they amended the system so patients did not receive any calls or correspondence regarding any routine check-ups or reminders during the period of bereavement.

The practice had a small waiting room with hot and cold drinks available to purchase whilst patients were waiting to be seen for their appointments. This room also had health care information leaflets for patients to browse through whilst they were waiting. We observed that a number of health information leaflets were displayed around the practice in communal areas and on the practices website.

The practice manager told us they were in the process of developing a carers group and would displaying information for carers in the near future. Carers were flagged on the system so GPs and nursing staff could easily identify those who may need additional support. The practice had organised a carers awareness evening, to share advice and additional support they could receive either from the practice or other support agencies. This evening had worked well and the practice intended to try another evening for patients who were suffering with depression. The practice was in the process of starting an official carers awareness group in September.

Patients were greeted by GPs and nurses in their preferred manner and conditions were not discussed in a way which could undermine their privacy. We observed there were curtains and blinds in the treatment rooms, this provided patients with privacy and dignity when receiving intimate or personal care. The treatment room door was lockable and ensured minor surgery and intimate examinations were not interrupted. Staff told us about the importance of not rushing patients and giving patients time to talk.

The practice offered a chaperone service. A chaperone is a member of staff who has a supportive role for a GP or nurse and a patient during a medical examination or treatment. This service was provided by one of the nursing team on request of a GP or nurse, if a patient wished this. The practice advertised this service to patients in the waiting areas of the practice. GPs or nurses asked the patient if they wanted a chaperone when appropriate. There was never any need to use a receptionist because there was always a duty nurse or GP available to assist with any requests.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with

Are services caring?

their GP. One of the GP partners we spoke with told us they involved patients in care and treatment decisions by talking through the pros and cons of treatment, so an informed decision could be made by the patient.

Patients were supported to understand the assessment process, any diagnosis given and their options for care and treatment. A patient told us they were given information leaflets a condition they had been diagnosed with to aid their understanding of it.

Patients were communicated with in a way that they understood and was appropriate and respectful. The practice had used an interpretation service for patients where English was not their first language. The practice had a hearing loop installed to assist patients who were hard of hearing and who wore a hearing aid. The practice had an equality and diversity champion. We were told they had attended external training on equality and diversity. The practice intended them to cascade what was learnt to other members of staff. One of the GPs had a lead role as a dementia champion and had involvement with the local dementia group. This involvement, cascaded through team meetings, kept practice staff up to date with current guidance and provided staff with a point of contact for any queries.

Decisions about or on behalf of patients who lacked mental capacity to consent to their treatment decisions were made in the patients best interest in accordance with the Mental Capacity Act 2005 and Gillick competence framework. The MCA is a framework which supports adults who need help to make decisions. The Gillick competence framework supports children who wish to make a decision without their parent or guardian present. Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. The practice used assessment of capacity forms from the British Medical Association to aid decision making in patients best interest.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to design services. The practice had listened to 485 patient views following the latest patient survey from 2013 to 2014. The survey showed that 87% of views about the care and treatment provided were good, very good or excellent. One of the areas for improvement highlighted was accessing the practice to book an appointment on the telephone. In the last year the practice had responded to these comments and changed its telephone appointment system to improve the ease of access for patients.

The practice actively engaged with commissioners of services, local authorities and other health care professionals to provide coordinated and integrated pathways of care that met patients needs. The practice was involved in various multidisciplinary monthly meetings which involved palliative care nurses, health visitors, mental health nurse and district nurses. They discussed vulnerable patients who might be at risk and had complex health needs and how they reduced hospital admissions. The lead GP for safeguarding children attended a weekly child protection meeting with the local midwife and health visitors.

The practice had eight male GPs and six female GPs, who were either partners or associates within the practice. The practice encouraged patients continuity of care with their allocated GP. Patients over 75 years and patients with complex health care problems all had an allocated GP. The practice manager told us that the practice tried to ensure patients were provided with appointments with their preferred or allocated GP. However, this could sometimes be difficult for same day appointments. Patients had a choice of seeing a male or female GP for their appointments.

The practice ensured there was a range of appropriate service provision to meet patients needs. The practice provided a range of services which were usually provided in secondary care services. The practice also provided specialist care and treatment to a vulnerable group of patients. They ensured members of staff providing care and treatment to these patients were trained and supported.

Patients referred to hospital were supported to choose a hospital or service that met their preference. Patients could use the NHS chose and book system for their hospital referrals, if there was a choice available for the treatment they needed.

The practice provided another additional service called dermoscopy (this helps to identify benign lesions as part of the early diagnosis of skin cancers which could help to reduce referrals to hospital). This improved early diagnosis for patients and helped reduce waiting times at hospitals. The practice was in process of completing a dermoscopy audit to establish if referrals to hospital had been reduced since implementing this service for patients.

The practice provided an ear, nose and throat (ENT) service to its patients and the public. This included treatments such as microsuction (ear wax and other debris removal technique which allowed treatment for patients who cannot have their ear syringed in the usual way). Normally patients are referred to hospital for this treatment.

Access to the service

Most patients told us they found it easy to make appointments and were seen on the same day if necessary. There was an accessible appointment system, which supported patient choice and enabled the patients to access the right care at the right time. The practice had recently implemented a new appointment system to improve patient care. They now had a dedicated call handler room with dedicated staff taking calls. Staff levels were increased during the busiest times of the day. The practice had monitored call levels prior to implementing the system to determine staffing levels required. They had increased their administration team to reflect this. For example, they had six staff taking calls between the hours of 8:30am to 10:30am which made it easier for patients to get through to the practice to make appointments.

The practice had also introduced a duty GP system. The allocated duty GP sat within the call handler room to answer any queries from patients who either visited the practice or telephoned in. This GP would also assist in triaging calls for patients who requested appointments and call back patients who requested a telephone appointment. Administration staff told us this had improved prioritising patients who needed to be seen the same day.

Are services responsive to people's needs?

(for example, to feedback?)

Call handlers making appointments for patients gained a summary of why they wanted an appointment. Call handlers were given prompts for questioning so they could aid triaging calls. This enabled them to determine which member of staff was most appropriate to see them and prioritise the call. We saw staff had access to information which informed them which staff were trained or specialised in particular clinical areas. If the call handler was ever unsure about information provided by a patient then a duty GP was always available to deal with their query promptly. Also, the call handlers had been provided with training to prompt patients when they required a check-up. They could identify this through the patient appointment system and this proved to be another way which encouraged patients to make appointments for their reviews.

Patients were able to make appointments through an online booking system, as long as they had registered with practice beforehand. This helped improved access for patients who worked during practice hours or who were hard of hearing. The practice had asked patients if they would mind receiving text message reminders for things such as appointment reminders. Over 9000 patients had agreed to this service and the practice had started reminding patients in this way.

Following a home visit request by the patient, a GP telephoned the patient to carry out an assessment of need. If the patient was requesting an urgent visit and the GP assessed they were likely to be admitted to hospital, then they would refer the visit to the emergency care practitioner team. Emergency care practitioners have enhanced skills in medical assessments and were well placed to decide if the patient required hospital admittance or a referral to community care services.

One of the GPs told us patients with complex problems were detailed on a board where the duty GP was based. These details enabled them to quickly gather any additional essential information such as a secondary GP name if the patients main GP was not available.

Concerns and complaints

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

Patients we spoke with were not aware of how to officially complain about the practice. However, they did tell us they would ask to speak to a manager if they were not happy. We observed that there was no information displayed, in the practice waiting areas, for patients about how they could complain about the service or contact an advocacy service to assist them. Our expert by experience spent time trying to find this information. Although there was information in the practice information leaflet kept on the reception desk. This did not easily allow an open environment for patients to find this information without staff being made aware.

There was information available for patients on how to complain on the practice website, if patients had access to the internet. This information on how to complain was slightly different from the information leaflet provided to patients if requested at the practice. It did not describe accurately how patients could escalate their complaint through the external authorities, if the patient was not satisfied with the practice response to their complaint.

The practice had a dedicated staff member called a patient services coordinator. Part of their role was to support patients if they were unhappy with the service provided. The patient services coordinator would work alongside the practice manager to help rectify the situation. They were also involved in gaining patient views about the practice. They carried out mini surveys by asking patients who were waiting about potential changes to the service provided. For example, a telephone questionnaire was completed recently to establish if patient satisfaction had increased since the changes had been implemented. The results had not been collated yet. They also planned on asking patients about whether they would be more likely to read the television monitor displayed in the waiting area. For example if it had additional information on it, such as the complaints process or signposting for local support groups.

The practice continuously reviewed and acted on information about the quality of care received by patients. We saw the practice monitored complaints received. The practice manager had analysed the complaints and had discussed them in a team meeting. This enabled learning points to be raised and identified how any changes to practice would be embedded. It had been established that complaints were mainly around communication over

Are services responsive to people's needs?

(for example, to feedback?)

changes of processes and procedures. The practice aimed to improve communication with patients in the practice through the new practice reference group to help minimise future complaints.

Are services well-led?

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

Our findings

Leadership and culture

The practice had clear vision and values to be recognised as a high quality service by patients, staff and other professionals and wanted to become a business that thrived so they could invest in their staff to improve outcomes for patients. Practice goals were displayed for staff to read on the staff noticeboard. Staff told us about the practice values and we heard and saw examples of compassion, dignity, respect and equality towards patients throughout our inspection. Patients were informed of the practice values through the patient charter on the practice website.

The practice had a strategy to continuously improve patient care and treatment. One of the GP partners told our accompanying GP specialist advisor that business meetings held with the other partners and practice manager were held every one to two weeks. The partners also organised occasional away days and half days where they discussed improvements to services for patients. They held these meetings to discuss the practice business plan and talk through ideas for improved service provision. Decisions had been made in these meetings to extend the practice building and to add additional services, such as implementing the scanner which assisted with diagnosis for osteoporosis.

The practice had developed over the last seven years and was now a teaching, training and research practice which was part of the primary care research network. Individual GPs led for different training areas, such as medical students, junior doctors and GP Registrars.

It was evident throughout our inspection that the management team encouraged cooperative and supportive relationships amongst staff teams and support services. Staff told us they felt supported, valued and motivated. We observed staff willing to help others and work as team throughout our inspection. Staff told us the practice manager encouraged them to be open, honest and to raise concerns to them directly.

The practice monitored staff performance through competency checks, staff contracts of employment and appraisals. We heard of an example of where poor staff performance had been managed by the practice and action had been taken to address issues raised.

Governance arrangements

The practice carried out governance arrangements to support transparency and openness. We saw the provider had a range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance. Policies and procedures were kept on a computer system for staff to access centrally. When a member of staff had read a policy then the system registered this and the practice could monitor and identify staff who had not read the appropriate policies. The practice manager followed this up with the member of staff if they had not read particular policies by a certain time.

All GP partners, associates and nurse practitioners had lead roles within the practice. This included safeguarding, occupational health, teaching and training, infection control and learning disabilities lead. This enabled staff to gain expertise in these areas and share their knowledge with other staff within team meetings or through other communication systems within the practice. For example, the infection control lead would attend external infection control training and then cascade training to other members of the team. Staff told us they spoke with the safeguarding lead if they had any issues and they raised them through appropriate multidisciplinary meetings.

Systems to monitor and improve quality and improvement (leadership)

The practice is involved in a programme called 'productive general practice' supported by the NHS Improving Quality. One of the GPs led on this and they told us the programme sought to provide better care through a structured whole practice approach. So far the practice had achieved this by empowering members of the administration team, such as dealing with safeguarding correspondence with the GP having the overall responsibility.

The practice had been accredited with the Royal College of General Practitioners quality practice award. This was awarded in recognition of how they improved patient quality care and outcomes, and had demonstrated good practice and organisational and clinical excellence in their practice.

The practice had created a role called a patient services coordinator. This role was established to be an advocate for patients in the practice including setting up a patient reference group and training staff with direct contact with patients in customer service skills. The patient services

Are services well-led?

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

coordinator analysed why patients were admitted to hospital and whether this could be reduced, particularly for patients over the age of 75 years. They held multidisciplinary meetings with the emergency care practitioners, GPs, palliative care and district nurses where they discussed admittance to hospital and how this could be reduced and community services used instead. If patients were assessed as being at risk of being admitted to hospital in the next year then a care plan was agreed with the patient. The practice intended to complete all required care plans for supporting patients by September 2014. The outcome for the practice was reduced admissions to hospital and to provide an advanced service to patients.

We saw evidence of clinical audits that had been undertaken, for example we saw an audit from July 2014 for cervical smears that had been taken and were deemed as inadequate over a two year period. The purpose of the audit was to identify the number of inadequate smears and see if any learning from this could improve the procedure. The audit did not identify what the outcome of this audit was and actions taken from it. The practice had identified that they did not always review each other's audits to gain learning from them.

Patient experience and involvement

Patients spoke highly of the service and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. Patients felt the repeat prescription process was effective and easy to undertake. Patients were given advice about the pros and cons of their medicines to enable them to make an informed decision.

The practice had created a staff role called a patient services coordinator. This role was established to be an advocate for patients in the practice and included setting up the patient reference group and training patient facing staff in customer service skills. They also completed short surveys to gain views from patients about changes in the practice, such as if patients would read information from the screens in the waiting area rather than leaflets and posters displayed.

We reviewed other sources of what patients experienced with the service provided prior to our inspection. This included NHS Choices (a forum for patients to provide their views about the service publicly and where the practice responds to their views). We saw patients had made five comments in the last year. The practice had responded to these comments and had asked the patients to contact the practice. The two patients were mainly not satisfied with the communication with staff and unable to book pre-bookable appointments. The practice had made changes to the appointment system to improve pre-bookable appointments.

We also reviewed the national GP survey results from January to March 2013 and July to September 2013 (this is a national survey sent to patients by an independent company on behalf of NHS England). One hundred and twenty-four patients completed the survey and this showed areas for improvement, such as ease of access on the telephone and level of privacy in the reception area. We saw the practice had made or was in process of completing improvements to the service to improve patient satisfaction in these areas.

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

The practice recognised that it was important to gain a range of views from patients using the service. Because the average age of patients was 38 years old, they wanted to ensure they were gaining a good proportion of views from all ages of the patient groups. Following their own research they decided against a patient participation group because the interest for this was mainly from the older retired population. They have since decided to have a virtual group. The practice intended that this would encourage patients with families or who worked to participate because they would not need to visit the practice to provide their views. The practice aim was to have 100 patients in their virtual patient group and so far they had 70 patients involved.

The practice fed back to patients through a practice newsletter. This provided updated information about the services provided and any changes made to the practice and the services provided. The newsletter was available on the practice website for patients to view. They also included the patient survey results on the website. Although these results showed 87% satisfaction with the service provided. There was no information available to inform patients whether they had improved from last year or what they were planning to do to improve the latest results.

Are services well-led?

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

The practice actively sought patient views and had organised an open evening in September 2014 to talk with patients, staff and the public about how to improve the practice. They also embraced current technology and had social media accounts. This enabled the practice to update these forums with their latest news and patients or members of the public could provide feedback about the practice to help speed up practice improvements.

Management lead through learning & improvement

The practice management team had systems in place to enable learning and improve performance. The practice management team involved patients, staff and other services/professionals when they considered how to improve the service provided.

The practice learnt from patient feedback and quality assurance activities and had made a number of significant changes recently. This included implementing a new appointment system to improve ease of access for patients to book appointments. The practice had closed their branch site and built an extension on the existing practice and increased the number of staff available which enabled the same capacity of patients to be seen. The practice had also changed prescribing patients medicines to electronic prescriptions. This enabled patients to choose the pharmacy of their choice to pick up their prescription and the patient would receive their prescribed medicines within a shorter timescale.

Identification and management of risk

The practice regularly assessed risks to the practice. This included reviewing significant events, complaints from patients and reviewing patient risks through multidisciplinary meetings. For example, the practice had identified a risk when a patient had tripped outside on a step. Initially they had closed off the area then subsequently provided gated access to the pathway, to help reduce the incident from happening again.

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 operated a system where patients who were 75 years and above were allocated a named GP. These patients were given priority to see their allocated GP and if this was not possible then they were allocated a secondary GP which ensured further consistency of care.

The GPs conducted home visits for older patients, if they were unable to visit the practice independently. The practice assessed patients for home visits through a triage system. If a patient requested a home visit, unless otherwise stated on the system, then the duty GP would contact them beforehand to assess their need.

The practice had undertaken recent work to identify and assist patients who had caring responsibilities. They were in the process of setting up a carers forum to enable signposting to local support groups.

There were monthly meetings with a multidisciplinary team consisting of community district nurses, the practice mental health nurse consultant and the palliative care team to discuss and meet the needs of patients with complex health care needs.

The practice was adapted to support older patients who were frail or who had a disability to visit the practice. For example, the reception area had a hearing loop installed and there were facilities for disabled patients such as accessible toilets and level access consulting rooms.

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

All patients who were diagnosed with a long term health condition, such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes, had an alert flagged on the computer system and were allocated a named GP for consistency. This ensured all staff were made aware additional services were available to these patients, such as patients being given longer appointment times and same day appointments. Patients with COPD were also given a rescue medicine self-start pack, allowing them to self-start treatment if symptoms indicated an escalation of their condition, allowing prompt treatment for infections.

Staff had the skills, knowledge and competence to respond to the needs of patients with long term conditions. Patients were able to see two nurses who specialised in diabetes and respiratory conditions. Management of long term conditions was also supported by the community matron (for COPD) or district nurses (for diabetes). One of the practice nurses had run a diabetes awareness evening approximately six months ago. This was held to provide an open forum and discussion about diabetes and raised patient awareness about how to better manage their diagnosed condition.

The nursing staff coordinated annual check-ups and followed up any missed appointments with individual patients. The practice informed patients to book their annual appointment for health checks in the month of their birthday. They hoped this would lead to increased participation as it may be easier for patients to remember if their check-up was due in their birthday month. The nurses also followed the Avon care pathway for patients with long term conditions. This pathway reviewed patients prescribed medicines and social factors that may affect their health. They also encouraged self-awareness of their own care and treatment to increase independence with managing condition.

Unplanned admissions and readmissions to hospital were reviewed by the practice and patients with long term conditions were managed with a support plan which aimed to reduce hospital admissions.

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

Concord medical centre is based in a predominantly family and working population area. The average age in the practice was 38 years old. Out of the 13,993 registered patients 6% were children under the age of 5 years old and 15% of patients were aged between 5 and 18 years old.

The practice had a safeguarding children lead practitioner and all GPs and nursing staff were trained in level 3 child protection by an external provider. Children who were assessed as 'in need' or 'looked after' were flagged on the patient record system alongside their family members to inform staff of their situation and relationships. Children of parents who were subject to domestic violence were also identified.

Regular monthly meetings were held with other professionals such as a health visitor and a midwife. The meetings discussed child protection cases or concerns around child health, where identified, to ensure a consistent approach to care and wellbeing was used.

GPs carried out six week baby and mother checks. One of the GPs we spoke with reported they carried out a 24 hour check after a mother delivered their baby at home.

The mental health nurse consultant employed by the practice supported new mothers who were diagnosed with post-natal depression.

Child immunisations were provided by the nurse and reminders were sent to the parent if there was non-attendance for appointments. Health care advice was provided by the nurse practitioners to children who were classed as obese. If necessary obese children were referred to a local outreach service to support families.

The practice displayed sexual health tests with a promotion poster in all patient toilets in the practice. This was to encourage patients from the age of 16 to 24 years old to take the test in confidence without staff and other patients seeing them. However, there was no other information about sexual health or signposting to other support services available for patients.

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 met the working age population needs by increased ease of access to make appointments by offering an online booking and cancelling service and extended opening hours. Patients could also order their repeat prescriptions through the online system.

The practice had extended its opening hours in the morning and evenings. Two days of the week the practice opened from 7:30am and one evening a week the practice opened until 8pm. Normal opening hours were from 8am to 6:30pm. Patients could book appointments with a GP and a practice nurse during these hours. The practice also opened on alternate Saturdays from 8:45 to 11:45am to help working age people to access their GP.

The practice provided a pre-bookable Saturday service to female patients who required a cervical smear or a contraceptive coil (Intrauterine device - IUD). The practice also provided respiratory checks on Saturday. The intention from the practice was to improve attendance for patients who worked in the week, working mothers and patients who needed assistance from carers and family members.

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 provided care and treatment to a number of patients who were in vulnerable circumstances. We were told the practice had an increasing number of patients who were subjected to domestic violence. GPs and nurses attended two training events to ensure they were fully aware of the issues surrounding domestic violence and how to support these patients. The practice used their patient record system to flag when a patient was known to be subjected to domestic violence.

The practice had specialist expertise in treating and caring for vulnerable patients from different cultural and background circumstances.

The practice had 41 patients registered who had been diagnosed with a learning disability. The practice had patients registered from a local learning disability care home. One of the GPs had a lead responsibility for patients with a learning disability. Patients with a learning disability were asked to attend an annual health check in line with national enhanced service guidelines. Patients with a learning disability benefited from an annual health check by the practice nurses. This included reviewing medicines to ensure they remained effective and any outstanding health checks could be completed. We saw 70% of the 41 patients had received an annual health check in the last year. The practice nurses encouraged attendance for these checks by sending reminders to the patient.

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 had 5% of patients registered at the practice with a diagnosis of depression and 62 patients who were diagnosed with a serious mental illness. Out of the 62 patients diagnosed with a mental health condition 78% had a current care plan in place. Physical health checks, such as blood pressure and cervical smear tests were carried out by the GP and we saw the amount completed ranged from 78% to 100% depending on the check.

The practice employed a full time mental health nurse consultant to see patients when they needed additional mental health support. The mental health nurse provided support for patients who were waiting for their appointment in specialist services. Patients had benefitted because the practice had employed a specialist in mental health nurse consultant as this provided more consistent care and treatment. The practice had also benefitted through reduced GPs workload with this patient group. We were told this had worked well for patients because they had a consistent member of staff to see and did not have to travel to other locations for secondary care appointments. The mental health nurse had regular meetings with the lead GP to avoid professional isolation and to share patient information.

One of the GP partners we spoke with told us they had identified the additional external support from a GP with a specialist interest in mental health to offer professional support and develop expertise amongst the partnership.

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
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider must protect patients against the risks associated with medicines with the unsafe management of medicines by making appropriate arrangements to record, safe keeping and disposal of medicines.**