DR KLEMENZ & PARTNERS

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Klemenz and Partners on 7 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

• Risks to patients were assessed and well managed, with the exception of those relating to Legionella.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly, the provider must:

- Review access to the repeat prescribing system and how it is used.
- The practice must ensure prescription pads which are completed by hand are stored securely and auditable records are kept.

In addition the provider should:

- Review how they manage expiry dates which change when medicines are stored at different temperatures.
- The practice should consider keeping records of how they responded to alerts including medicine recalls.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where improvements should be made.

Systems were in place for reporting, recording and monitoring significant events. Infection prevention and control systems were in place and regular audits were carried out to ensure that all areas were clean and hygienic.

Appropriate checks were made on all staff before they started to work. Staff files were comprehensive and complete.

Arrangements relating to the availability of safe and secure storage of medicines and vaccinations was not effective. We saw that safety features within the repeat prescribing system including "review dates" and "percentage medicines use" were not used consistently. We also observed that the computer access levels granted to reception staff allowed them to change prescribing parameters. Therefore, we were not assured that patient's repeat prescriptions were still appropriate and necessary.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence guidance was referenced and used routinely. Multidisciplinary working was also evidenced. Patients' needs were assessed and care planned and delivered in line with current legislation which included assessments of a patient's mental capacity. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatment they needed in a timely manner. Staff had annual appraisals and told us that their training needs were supported by senior staff.

Are services caring?

Good

The practice is rated as good for caring.

Patients told us that they were well informed about their care and treatment. We observed patients being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient privacy, dignity and confidentiality when registering or booking in patients.

All the patients we spoke with, and the comments we received were complimentary of the care and service staff provided.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice understood the needs of their patient population and this was reflected in the practice environment and systems used to meet some of the needs of their patients.

Patients told us they could always get an emergency appointment the same day and waiting time for routine appointments was satisfactory.

The practice obtained and acted on patients' feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care.

Are services well-led?

Good

The practice is rated as good for well-led.

There was a clear leadership structure and staff felt supported by management and a culture of openness and honesty was encouraged.

The staff worked as a team and ensured that patients received a high standard of care. Staff had received induction, regular performance reviews and attended staff meetings.

Risks to the safe and effective delivery of services were assessed and addressed in a timely manner. A suitable business continuity plan was in place. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with greater needs. The practice cared for 20 patients living in four care homes for older people in their catchment area.

The practice also interacted with the voluntary sector, community geriatrics and older mental health services.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions.

The practice had a good system for surveillance of long term conditions and maintained an up to date register. Regular practice meetings were held to plan and review actions and to alert and update team members. The practice had 90 patients on the long term conditions list. This was approximately two per cent of the practice list.

Patients in this population group received safe, effective care which was based on national guidance. Care was tailored to patient needs, there was a multi-disciplinary input and was reviewed regularly.

The practice provided regular clinics for patients with diabetes, respiratory and cardiac conditions

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice followed national protocols and staff were aware of their responsibilities and the various legal requirements in the delivery of care to people in this population group. They worked with other health and social care providers to provide safe care.

Summary of findings

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an appropriate way and recognised as individuals. We were provided with good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people (including those recently retired and students).

There was an appropriate system of receiving and responding to concerns and feedback from patients in this group who had found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs of this population group. The practice held a surgery 9am to 12.30pm on alternative Saturdays for those patients who found it difficult to get to the practice during normal working hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group whose circumstances may make them vulnerable.

There was evidence of good multidisciplinary working with involvement of other health and social care workers. Staff were trained on safeguarding vulnerable adults and child protection.

The practice monitored a register which included patients receiving end of life and palliative care on a Gold Standard framework. The practice liaised on a regular basis with a community matron to ensure that any changes to patients' conditions were discussed.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including patients with dementia).

The practice ensured that good quality care was provided for patients with mental health illnesses. The practice had a nominated lead who linked with other health professionals and community teams to ensure a safe, effective and co-ordinated service. The practice offered proactive, personalised care that met the needs of the older people in its population and had a range of enhanced services, for example in dementia. Data showed that this practice was in line with the national average score for dementia diagnosis in older patients.

Summary of findings

Adults with mental health issues were included within a monitored list. We saw evidence of discussions by the GPs and other healthcare professionals concerning a patient with psychotic illness (schizophrenia) with coexisting organic problems.

Patients, who had a learning disability, were supported to live independently in the community.

Summary of findings

What people who use the service say

During our visit we spoke with eight patients and a representative from the patient reference group. We reviewed 37 comments cards from patients who had visited the practice in the previous two weeks. All the feedback we received was positive.

Patients were complimentary about the practice staff team and the care and treatment they received. Patients told us that they were not rushed, that the appointment system was effective and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Data showed that the practice was above the national average for the proportion of respondents to the GP patient survey who stated that they always or almost always saw or spoke to the GP they preferred. The practice was also above average for the percentage of patients who described their overall experience of their GP practice as fairly good or very good.

Areas for improvement

Action the service MUST take to improve

Review access to the repeat prescribing system and how it is used.

The practice must ensure prescription pads which are completed by hand are stored securely and auditable records are kept.

Action the service SHOULD take to improve

Review how they manage expiry dates which change when medicines are stored at different temperatures.

The practice should consider keeping records of how they responded to alerts including medicine recalls.

DR KLEMENZ & PARTNERS

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, CQC inspector with expertise in managements of medicines and a practice manager advisor.

Background to DR KLEMENZ & PARTNERS

Dr Klemenz & Partners also known as the Northern Road Surgery, 56 Northern Road, Cosham, Portsmouth PO6 3DS has been on the present site for some years, having previously been in Cosham High Street. This is a Personal Medical Services Practice operating as an independent contractor to the Portsmouth CCG.

The practice is staffed by two full time GP partners both male and two long term locum GPs both female.

Dr Klemenz, the senior partner has been at the practice since 2000 and Dr Karim the other partner, since August 2014.

The two female locum doctors do two clinical sessions per week each and between them, cover four days per week and informally cover one another for absences.

The list size is stable at around 4000 patients and the practice is situated close to Paulsgrove, a large council estate area with a high deprivation score.

Out of hours services are provided by Solent Healthcare.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. Such as from local NHS England, Healthwatch and the clinical commissioning group. We asked the practice to send us information about them, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 7 January 2015.

During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, administration staff and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The GPs worked to assist the acting practice manager on governance at the practice and monitored incidents, near misses and significant events. The practice GPs met on a regular basis to discuss safety of patients and safe care of patients. Any learning points were discussed openly and any actions were taken and systems changes were made where appropriate.

Adverse events and safety issues were discussed and documented regularly each month. All four GPs, one nurse, one health care assistant and the acting practice manager attended these meetings. We saw minutes of meetings which confirmed this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the acting practice manager and the GPs. All serious events were discussed at GP partners' meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points.

We saw an example where systems within the practice had been changed to minimise further risks. An unsheathed needle was discovered in a specimen bottle placed in a desk drawer. This was reported and investigated and openly discussed. A GP had used it on a house call and not having a sharps disposal bin to hand had returned with it to the practice intending to dispose of it there but had then forgotten to do so. The action taken to prevent this happening again was to provide each GPs bag with a mini-sharps disposal unit such as used by insulin dependent diabetics. There have been no issues since this procedure was adopted.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children at an appropriate level for their role.

One of the GP partners who took the lead in safeguarding had taken part in level three training in the subject. The practice was arranging safeguarding vulnerable adult training for staff.

Staff we spoke with were clear about their responsibilities to report any concerns they may have. Staff gave examples of safeguarding, when they would have had concerns and how they would deal with those concerns. Any case of concern was discussed during the clinical meetings. Staff were able to give examples of when they had raised concerns about child safeguarding.

Staff were also aware of the practice "whistleblowing" policy and understood it.

The practice offered patients the services of a chaperone during examinations if required. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Staff told that this service was offered to patients and reception staff were trained, but chaperone duties were usually performed by the nurse or healthcare assistant.

Medicines management

We checked medicines stored in the treatment room and medicine refrigerators and found they were stored securely. Practice staff monitored the refrigerator storage temperatures and appropriate actions had been taken when the temperatures were outside the recommended ranges.

Processes were in place to check medicines were within their expiry date and suitable for use including expiry date checking. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using Patient Group Directions that had been produced in line with national guidance and we saw up to date copies. There were also appropriate arrangements in place for the nurses and health care assistant to administer medicines that had been prescribed and dispensed for patients.

Staff explained how the repeat prescribing system operated. For example, how staff generated prescriptions, monitored for over and under use and how changes to patients' repeat medicines were managed. However, we saw that safety features within the repeat prescribing system including "review dates" and "percentage

medicines use" were not used consistently. We also observed that the computer access levels granted to reception staff allowed them to change prescribing parameters. Therefore, we were not assured that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Staff told us that most high risk medicines were not "on repeat" and when requested, a GP would generate the prescription, if appropriate. Whilst most prescriptions were for 28 days, prescriptions of shorter durations were issued where clinically appropriate.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Whilst blank computer generated prescription forms were stored in accordance with national guidance, hand written prescription forms were not appropriately controlled, nor were they tracked through the practice.

Cleanliness and infection control

A nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises and especially the nurses' treatment room appeared clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with well sighted information and clean privacy curtains, sharps boxes and foot operated waste bins. We spoke with one of the nurses who clearly described the procedures in place to maintain a clean and safe working environment.

Hand washing guides were available above all sinks both in clinical and patient areas. There was a good supply of bacterial soap pump dispensers and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Equipment

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurse to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise.

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment by a contactor were seen. Continual risk assessing took place in the different areas of the practice and we saw evidence of the assessments in the health and safety file.

Staffing and recruitment

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included appropriate references, and where required criminal record checks, such as using the Disclosure and Barring Service (DBS).

The staff told us that they had worked at the practice for a number of years. The acting practice manager and GPs told us that they felt the stable and experienced work force provided a safe environment for their patients. Staff at this practice worked as a team to cover the practice opening hours and would adjust their hours to cover any sickness or annual leave during practice opening hours.

Both locum doctors went through a formal appointment process when joining the practice information on satisfactory conduct in previous employment was obtained; their qualifications validated; medical defence checks performed; performance list and DBS checks completed. Induction for both locums was informal, there were no issues raised at the time. They were both happy to remain in post long term.

Monitoring safety and responding to risk

Emergency medicines were available in secure areas of the practice and all staff knew of the locations. Processes were in place to check emergency medicines were within their expiry date and suitable for use, however we identified one product where the storage had changed and the expiry date had not been appropriately reduced.

The practice conducted regular fire drills to ensure fire safety was high. There was a continual risk assessment of practice treatment and waiting areas and evidence of the assessments was found in the Health and Safety file.

Requires improvement

Are services safe?

Fire risk assessments were found. Equipment testing and fire extinguisher testing were up to date. Equipment was checked regularly and when sourcing new equipment, required standards were checked.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency drugs and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do if there is an interruption to services to ensure that their patients are still able to receive a service.

Staff had taken part in annual emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had regular weekly meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of people. The practice also used local Portsmouth authorised guidelines and reviewed details for the following clinical areas: chest pain, cancer, liver pathway, other cardiology. The meetings also covered various clinical issues, an example seen was in regard to individualising new patient care; all new patients were offered new patient checks. Other NHS checks and chronic disease management appointments were offered.

We looked at examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not. We saw evidence of reflection at the end of the full cycle. There was evidence of learning from the audit process. A recent example see was a Sitagliptin audit for Type 2 diabetics. All diabetics on gliptin had 6 monthly A1C blood tests to determine whether this treatment was to continue.

At the time of our visit the practice was also reviewing referral rates in liver disease which was high, but was explained by the higher than average prevalence of alcohol induced illness in the practice population.

Management, monitoring and improving outcomes for people

The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes. The practice used the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities, had a complete register available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Effective staffing

Staff we spoke with all told us that they felt well supported by their colleagues and the GPs. They said they had been supported to attend training courses to help them in their professional development and that there was a culture of openness and communication at the practice and they felt comfortable to raise concerns or discuss ideas.

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

All GPs participated in the appraisal and revalidation processes. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

The GPs were aware of mandatory training areas and were up to date with such things as basic life support, child & vulnerable adult safeguarding and Mental Capacity Act training.

The practice took part in joint learning with other Portsmouth practices for all staff (clinical & non-clinical) through monthly training meetings on Wednesday afternoons. Recent topics were, fire safety, basic life support and safeguarding.

Working with colleagues and other services

The provider worked in co-operation with other services and there was evidence of good multi-disciplinary team working. Gold Standard framework meetings were held monthly with the community matron and GPs. The practice treats this as key area which ensures that care given is tailored to individual needs and ensured that practice clinicians and staff together with the district nursing team and Out of Hours services are coordinated and remain well informed of patients' needs.

The practice had regular discussion and meetings with the local Clinical Commissioning Group (CCG) about care provision in the area. They had focussed specifically on non-elective admission reduction, referral reduction, mental health and medicines management. The CCG prioritised areas for improvement including respiratory,

Good

Are services effective?

(for example, treatment is effective)

stroke, diabetes, end of life care and health inequalities. These impacted on the practice as it had relatively high deprivation with higher than average prevalence of diabetes, respiratory disease and alcohol dependence.

Local bereavement counselling was available by a local funeral service. Those in need were actively encouraged to use this service via self-referral. The practice had good links with a local hospice which promoted shared care.

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement of other social and healthcare professionals especially in the care of the elderly.

Information sharing

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

The practice lead on information governance explained that staff were given training where confidentiality was discussed. Staff we spoke with were able to explain the training they had received about information sharing. For example when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the clinical staff.

When required information was shared in a responsible and comprehensive way. For example such as care plans for vulnerable patients were shared with ambulance and Out of Hours services. A medical secretary was responsible for choose and book referrals and updating care pathways. Summarising of medical records was carried out by designated administration staff that followed a protocol.

Consent to care and treatment

The practice nurse demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and a patient we spoke with confirmed that they understood about giving consent and did not feel pressured into agreeing to treatment.

Young people were able to access the practice and have their confidentiality maintained. GPs told us that there were no age barriers. They would make an assessment based on Gillick competency about whether a patient under the age of 16 years was able to make an informed decision.

When the GP or the nurses deemed the patient did not have capacity to consent then they discussed the matter with the next of kin, carer as well as fellow professionals.

Health promotion and prevention

The practice ensured that where applicable people received appropriate support and advice for health promotion. Information available to patients was effective we saw notices relevant to the demographics of the patients. An example seen was leaflets signposting young people to sexual health services in the local community.

The practice website gave details of clinics and advice available, for example family planning, healthy living and smoking cessation support. The website also had links to NHS information videos such as infections and viruses, first aid and information for older people.

The practice website and waiting areas had information on health promotion and self-management of conditions. Such as, sexual health, heart disease sign and symptoms and advice on coughs and colds.

The practice sent out a newsletter at various times of the year and we saw that an article described how patients who were diagnosed with hypertension were provided with a blood pressure monitoring machine, which they were taught to use at home. They would then be sent text messages by the practice reminding them to take their blood pressure and text the recordings back. This was a free service including the text messages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were always treated with dignity and respect and that their privacy was always a priority. One patient told us that they had been a patient at the practice for over 40 years and had seen many changes for the better. The patient said that the staff were always polite and that the GPs listened to them and treated them with respect and compassion.

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly to where they needed to go. There were signs that asked for patients to respect the privacy of others. The practice had set aside an area for patients to use if they required further privacy to discuss any matter.

Phone calls were answered professionally and with a friendly greeting, confidentiality was maintained, at no time did we hear anyone mention names or diagnosis or treatment.

The practice communicated with the Out of Hours service and made them aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and the comment cards completed were all complimentary of the staff at the practice and the service received.

Patients told us that they felt listened to and involved in the decisions about the care and treatment. Patients expressed their views and were given appropriate information and support regarding their care or treatment. Patients told us that the GPs took time to explain things to them. Patients said they had the opportunity to ask additional questions if they needed to and felt their concerns were listened to.

One patient described their care plan to us and confirmed that they understood the plan and were involved in the decisions. The plan was kept up to date and amended to address their changing needs.

The practice had regular monthly clinical meetings which included, referral reviews, care plan reviews and Individual case reviews. There are also frequent informal meetings to discuss the care of patients.

Patients who were receiving end of life or palliative care were discussed at monthly meetings, which involved other health professionals such as district nurses.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

The practice had a good system for surveillance of long term conditions and maintained an up to date register. Regular practice meetings were held to plan and review actions and to alert and update team members. There were about 90 patients on the list which was about 2% of practice list. The practice looked to support, as much as possible, the patients and carers.

An example we looked at included support given to a patient with multiple complex morbidities including Type 2 Diabetes, hypertension, gross obesity and sleep apnoea.

The list included patients in terminal illness and palliative care to a gold framework of support involving the community matron with whom the practice had regular contact.

Vulnerable adults, for example those with a mental health diagnosis, were also included within this list. The practice had discussions concerning supporting a patient with poor mental health and coexisting organic problems.

A special notes system was used for updating out of hours services with details of patient carer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had worked with a new patient reference group to produce a practice survey for the wider practice population. The patient survey undertaken earlier in the year showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice on the day of our visit. Some of the changes that the practice had agreed to make as a result of the patient survey results included that they updated the practice website and a review of the information displayed on the boards in the waiting area was completed.

Tackling inequity and promoting equality

There was wheelchair access to the practice with a lower door bell and wide front door. There was access to all the ground floor rooms. The practice did not have a lift to the upstairs consulting room, but if the patient mentioned to the receptionist that they were unable to manage the stairs, every effort was made to accommodate the patient on the ground floor.

The practice had a hearing loop installed in reception for the hard of hearing.

Staff told us that there was some diversity of ethnicity within their patient population. They were knowledgeable about language issues and told us about the language line available for people who did not use English as their first language. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

The practice opened to the public from 8.00am until 12.30pm, then 1.30 pm until 6.30pm Monday to Friday. At all times when the practice was open patients could make appointments, request repeat prescriptions, collect prescriptions and results of tests.

The practice offered a surgery 9am to 12.30pm on alternative Saturdays for those patients who found it difficult to get to the practice during normal working hours. The practice was not open during this time for booking of appointments, or collection of prescriptions.

Appointments with a GP were generally available between 9.00am and 11.00am, and 3.30pm and 6.00pm.

Appointments with the nurse were generally available at varying times between 8.30am - 12.30pm, and 2.00pm - 6.30pm.

One Wednesday afternoon each month, the practice closed for staff training. The practice used the services of an out of hour's provider when closed and details of how to contact this service was displayed on the website and an answerphone message.

The practice offered home visits and requested patients to ensure that requests for home visits were made before 10.30am.

Patients could order repeat prescriptions through the practice website and follow the practice on social websites.

Patients told us that the received text alerts to remind them of appointments and two patients told us that they had called the practice at 8.00am that morning and had been given appointments straight away. Another patient told us that they phoned the practice at 2.00pm and was given an appointment at 6.00pm which helped them to attend after work.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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 in the practice.

The practice had a culture of openness and learning. Staff told us that they felt confident in raising issues and concerns. We saw that incidents were reported promptly and analysed. Complaints were responded in a timely manner and audits were undertaken regularly to review the working procedures and practices which were amended when applicable. The complaints had been analysed to try and ensure that there were no repeat occurrences. The practice manager used the information to create learning points where required and these were fed back to staff for information. Also to support them where processes were correct and followed, and any complaint was unfounded.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to place patients' needs at the heart of everything it did. The practice had gone through some changes in staff due to retirements of GPs and long term sickness of the practice manager. The practice was making decisions about the registration of a new registered manager. Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice and all the GPs met regularly to support each other and discuss the care of patients.

At some point in the future it seems likely that the practice will either move to a more suitable premises or join with other local providers to form a larger unit probably working from multiple sites.

Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at governance meetings and action plans were produced to maintain or improve outcomes.

We saw good working relationships amongst staff and an ethos of team working. Partner GPs and the practice nurses had areas of responsibility, such as, prescribing procedures or safeguarding, it was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

The GPs and acting practice manager told us that they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. The GPs promoted shared responsibility in the working arrangements and commitment to the practice. For example, the individual areas of responsibility included dermatology, clinical commissioning, safeguarding and hospital admissions.

Staff we spoke with told us that they felt there was an open door culture, that the GPs and acting practice manager were visible and approachable. They also said that there was a good sense of team work within the practice and communication worked well. The patient satisfaction survey further illustrated the practice ethos of a caring and quality service provided for patients.

There was an open culture among colleagues in which they talked daily and sought each other's advice.

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

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We saw that all complaints were discussed and minutes taken at meetings with the clinical staff.

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received.

The practice had a patient participation group and the practice worked with them to help improve the care services. Patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning and improvement

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly. The practice acted on feedback from patients, the public and staff.

Are services well-led?

Good

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

One of the partners had a positive attitude towards teaching and training medical students and junior doctors. He was undertaking requisite training with a view to having medical students on placement from a local hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment we saw that safety features within the repeat prescribing system including “review dates” and “percentage medicines use” were not used consistently. We also observed that the computer access levels granted to reception staff allowed them to change prescribing parameters. Therefore, we were not assured that patient’s repeat prescriptions were still appropriate and necessary. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.