

Staveleigh Medical Centre

Quality Report

King Street
Stalybridge
Cheshire
SK15 2AE

Tel: 0161 304 8009

Website: www.staveleighmedicalcentre.co.uk

Date of inspection visit: 15 May 2014

Date of publication: 10/09/2014

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.

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask and what we found	4
What people who use the service say	6
Areas for improvement	6

Detailed findings from this inspection

Our inspection team	7
Background to Staveleigh Medical Centre	7
Why we carried out this inspection	7
How we carried out this inspection	7
Findings by main service	9
Action we have told the provider to take	22

Summary of findings

Overall summary

Staveleigh medical centre provided primary medical services in the centre of Stalybridge Monday to Friday. The practice is open between 08:30 and 18:00. The practice also provided home visits for people who were not well enough to attend the centre.

The majority of patients we spoke with during our inspection were happy with the care and treatment that they received. Care and treatment was provided in a clean and hygienic environment and there were systems in place to ensure the safety of patients, including infection control and child protection. However systems to ensure vulnerable adults were protected from harm were inconsistent.

Arrangements were in place for medicines such as, vaccines and emergency drugs within the practice and these were stored safely, apart from medicines within GPs bags for home visits. We identified gaps in the system to check medicines, resulting in out of date drugs including adrenaline being found in two of three GPs bags. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Medicines management.

Patients felt they received a caring service and told us they were involved in discussions about the health care they received and we saw patients being treated with sensitivity and respect by reception staff.

We found the service was effective in meeting the wide ranging needs of patients. The practice worked effectively with other health and social care professionals, as well as the out of hours service to provide coordinated care for patients.

The service was responsive to the needs of the patients attending the service. All staff had access to equipment, guidance, protocols and pathways to make clinical decisions and provide safe effective care for patients.

Staff described the service as well led and staff at all levels felt supported. Information to ensure staff were up to date was routinely shared with staff via email and through formal and informal meetings.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had a range of measures in place to protect people from harm, these included child protection and infection control. The practice had systems in place to investigate and learn from significant incidents. We identified inconsistency in the knowledge and understanding of adult safeguarding. There was, no clear policy or guidance in place for staff to follow, which could result in staff not responding to concerns about vulnerable adults in a timely manner. A management system was in place however we saw the system used to check the drugs kept in secure GPs home visit bags was not robust. During our inspection we checked three GPs bags and in two found medication to be out of date.

Are services effective?

The service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met, with patients involved in decision making. We saw comprehensive assessments of care and treatment were in place and support provided to enable people to self-manage their condition. The practice carried out audits to monitor patient experience, quality and to ensure treatment was being delivered in line with best practice.

Are services caring?

The service was caring. Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. We saw staff being helpful and sensitive to patient's needs. All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff we spoke with were able to explain to us how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision.

Are services responsive to people's needs?

The service was responsive to people's needs. The practice had an understanding of their patient population, and responded to meet people's needs. The service asked for patient feedback on an annual basis, and a suggestion box was available in the reception area. We saw evidence of changes that had taken place as a result of input from patients. There was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found complaints were fully investigated with actions and outcomes documented and learning shared.

Summary of findings

Are services well-led?

The practice was well led. Staff described a service which was 'supportive and open to learning', providing staff with training and professional development opportunities. Systems were in place to identify, assess and manage risks related to the service provided through a series of internal checks and audits.

Summary of findings

What people who use the service say

During our inspection we spoke with 13 patients. We also reviewed 26 comment cards patients had completed leading up to the inspection. The majority of comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

A small number of patients reported difficulty in making routine appointments in advance with a named GP, however they reported where emergency appointments were required, these were accommodated on the same day.

Feedback included individual praise of staff for their care and kindness and going the 'extra mile.'

We reviewed the results of the patient survey carried out by the practice during 2012/13 and saw 87% of all patient ratings about this practice were good, very good or excellent. The majority of results were in line with the national average based on practices of similar size. Areas in which the practice were below the national average were, seeing a GP of choice and seeing a GP within 48 hours.

Areas for improvement

Action the service **MUST** take to improve

The practice was in breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Medicines management, because patients were not protected against the risks associated with medicines because the practice did not have appropriate arrangements in place to manage medicines within GPs bags used for home visits.

Action the service **COULD** take to improve

Ensuring all staff had access to training, policies and protocols which help to protect vulnerable adults from abuse.

Although complaints leaflets were available to patients in the waiting area and displayed on notice boards and on the practice website, many of the patients we spoke with told us they would not know how to make a complaint.

Staveleigh Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Inspector** and a **GP specialist advisor**. The team included a practice manager and an Expert by Experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Staveleigh Medical Centre

Staveleigh Medical Centre provided primary medical services in the centre of Stalybridge Monday to Friday. The practice was open between 08:30 and 18:00. The practice has four GPs and at the time of our inspection a GP Registrar. The practice also has a nurse, two health care assistants and Phlebotomists among the clinical team. The practice is supported by a practice manager, office supervisor and a team of receptionists. There is also a health visitor, midwife and Podiatrist who provide clinics within the practice.

The practice provided a wide range of clinics and services for patients which included, Antenatal, Postnatal clinics and child immunisation for women and children, minor surgery and diabetes. Health Care Assistant Clinics also offer appointments for NHS health checks, well person health checks, management, support and advice for patients in stopping smoking as well as providing blood pressure checks and routine blood tests.

The practice also provided home visits for people who were not well enough to attend the centre. When the practice was closed patients were directed to Go to Doc the out of hours service.

The practice was responsible for providing care to 6700 patients of whom 98% were white British.

Staveleigh Medical centre is an accredited GP training practice for the North Western Deanery of Postgraduate Medical Education.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information about practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 15th May 2014. The inspection team spent seven hours at the Practice. We observed how people were being cared for and talked with carers and/or family members and reviewed information provided on the day by the practice. We spoke with thirteen patients and a range of staff, including receptionists, office manager, practice manager, GPs, practice Nurse, health care assistants and a trainee GP.

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, 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?

Are services safe?

Summary of findings

The practice had a range of measures in place to protect people from harm, these included child protection and infection control. The practice had systems in place to investigate and learn from significant incidents. We identified inconsistency in the knowledge and understanding of adult safeguarding. There was, no clear policy or guidance in place for staff to follow, which could result in staff not responding to concerns about vulnerable adults in a timely manner. A management system was in place however we saw the system used to check the drugs kept in secure GPs home visit bags was not robust. During our inspection we checked three GPs bags and in two found medication to be out of date.

Our findings

Safe Patient Care

We found that the practice had systems in place to monitor patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

A system to report, investigate and reflect on incidents of patient safety was in place, this included identifying potential risk and near misses.

From our discussions we found that GPs, nurses and health care assistants were aware of the latest best practice guidelines and incorporated this into their day-to-day practices.

Learning from Incidents

The practice had in place arrangements for reporting significant incidents that occurred at the practice. A 'significant events reporting policy' was available for staff so that they knew how to report incidents. We saw from the practice 'significant events register' and speaking with staff; they had carried out detailed investigations and provided detailed records of outcomes and actions taken in light of the significant events. We saw from minutes of meetings and speaking with staff learning from incidents was shared via team meetings and email.

Safeguarding

We saw the practice had in place a detailed child protection policy and procedure. All staff we spoke with were able to tell us how they would respond if they believed a child to be at risk. We saw procedures and flow charts were in place for staff to follow should they have concerns about a child. Where concerns already existed about a child, alerts were placed on patient records. These alerts were nationally recognised, so would transfer with a child to another GP or health provider where appropriate. We spoke with the GP who had responsibility for safeguarding; they had a clear understanding of their role and attended local safeguarding lead meetings.

The GP safeguarding lead told us although their role had traditionally been focused on children; they had recently taken on the role of safeguarding vulnerable adults. They were in the process of refining safeguarding policies and procedure for vulnerable adults, and this was an on-going agenda item at GP partners weekly meetings. We noted at

Are services safe?

the time of our inspection there was no policy and guidance for staff in relation to safeguarding adults, and training for staff was inconsistent. The majority of staff were able to tell us how they would respond to concerns about vulnerable adults, where they had concerns about any patient they would seek advice. We raised this with the practice and they told us they would ensure this was looked into as a matter of urgency to ensure patient safety.

Monitoring safety & Responding to risk

The practice manager had clear management systems in place to monitor the quality of the service provided and met weekly with the partners to monitor quality and discuss emerging issues. Systems were established to identify, assess and manage risks related to the service provided through a series of internal checks and audits, these included risk profiles, infection control, call answering and maintenance.

Weekly partnership meetings were held and minuted. During these meetings practice management, risk, significant events, and complaints were discussed and action agreed.

We found checks were made to minimise risk and best practice was followed. These included monitoring staff training and registration with professional bodies to ensure they had the right skills to carry out their work. Systems in place to monitor stocks of consumables and vaccines to ensure they were available, in date and ready to use.

Medicines Management

The practice held medicines on site for use in an emergency or for administration during a consultation such as vaccinations. Medicines administered by the nursing and health care assistants at the practice were given under a patient group direction (PGD). A PGD is agreed by doctors and pharmacists which allow nurses to supply and/or administer prescription-only medicines. This had been agreed with the local Clinical Commissioning Group.

We saw emergency medicines were checked weekly to ensure that they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated appropriately. However we saw the system for checking GPs medicines stored securely in bags used for home visits was not robust with no one taking the lead responsibility for ensuring the bags contained in date medicines before they were used for home visits.

During our inspection we checked three GPs bags and in two found medicines and emergency medication to be out of date. We saw in one GPs bag Adrenaline, which is used if a patient is experiencing anaphylactic shock and Furosemide, used for treating a range of conditions most commonly fluid accumulation owing to heart failure, was out of date by seven months. We highlighted our finding to the practice and these medicines were replaced immediately.

Cleanliness & Infection Control

The practice was found to be clean and tidy. Posters promoting good hand hygiene were displayed. We saw that the clinical rooms were well stocked with gloves and aprons and had hand washing guidance displayed by the sinks. The practice employed two cleaners and a clear cleaning schedule was in place. We saw infection control audits were carried out and where required, actions had been taken, this included investing in hand dryers in toilets and ensuring alcohol hand gel was available in all clinic rooms. These practices helped to protect patients from the risks of cross infection.

We looked at a copy of the infection control policy. The policy clearly set out the staff roles and responsibilities. Speaking with staff they demonstrated a clear understanding of their role in maintaining a clean and safe environment.

We were told that the practice only used single use instruments for procedures. We noted stock rotation and saw equipment was in date and stored appropriately. We saw fridge temperatures were monitored throughout the day to ensure medicines and vaccinations were stored safely and at the correct temperature in line with manufacturer guidelines.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. An up to date recruitment policy was in place which reflected safe and effective practices when recruiting staff. We looked at the recruitment and personnel records for three staff including the most recently recruited members of staff. We saw recruitment checks had been undertaken which included a check of the person's skills and experience through their application form, personal references, identification, criminal record checks and general health.

Are services safe?

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list which helped ensure that staff met the requirements of their professional bodies and were registered to practice.

Interview records, induction checklists and identification were available within personnel files for all staff, evidencing appropriate checks were carried out, ensuring staff were safe and suitable to work within the practice.

Dealing with Emergencies

There were robust plans in place to deal with emergencies that might interrupt the smooth running of the service. Within the business continuity plan there was clear guidance, with staff roles and responsibilities being clearly defined. We noted if the practice was unable to open; alternative premises had been identified from which a service could be provided for patients. We were told by the practice manager following a recent electrical power loss the plan had come into force successfully.

We saw fire safety checks were routinely carried out and a full evacuation was carried out annually. Fire safety marshals had been identified and details were displayed in the office, this ensured staff took appropriate action in the event of a fire alarm.

The practice made seasonal arrangements for patients by increasing clinics to ensure people who required flu

vaccinations were able to receive these in a timely manner. Patients with COPD (Chronic obstructive pulmonary disease) were contacted by letter in the winter with advice and guidance on how to self manage the condition, this included the use of rescue medication to help manage acute exacerbation as part of their self-management strategy. The practice nurse told us they had positive feedback from patients following this initiative and had helped patients to manage their condition at home. This led to reduced attendance at Accident and Emergency for people experiencing breathing difficulties.

Equipment

The practice had a robust plan in place to ensure all equipment was effectively maintained, in line with manufacture guidance and calibrated where required. This ensured equipment was safe to use and provided accurate measurements and readings.

Checks were carried out on portable electrical equipment in line with legal requirements. We saw records showing that oxygen cylinders were checked and maintained. However we noted the practice policy for checking the defibrillator said daily, but this was only recorded weekly. The practice manager told us they would ensure checks were in place in line with policy in the future. Speaking with staff they all told us they had available for use sufficient equipment to work safely and meet patient's needs.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met, with patients involved in decision making. We saw comprehensive assessments of care and treatment were in place and support provided to enable people to self-manage their condition. The practice carried out audits to monitor patient experience, quality and to ensure treatment was being delivered in line with best practice.

Our findings

Promoting Best Practice

We saw information available to staff, minutes of meetings and speaking with staff which demonstrated the care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of. They told us information was shared with them through the email system. The practice nurse and health care assistants told us they were supported by GPs and colleagues either in person or via telephone for support and guidance should this be required.

We noted staff had access to Mental Capacity Act 2005 guidance which outlined the five core principles. A checklist was in place to ensure staff were following best practice procedures when assessing patient's capacity to consent. Guidance was also available for staff where a patient wished to make an advance decision.

We saw for patients with long term health conditions such as diabetes and chronic obstructive pulmonary disease (COPD), checks and reviews were being carried out according to protocol and best practice guidance from the National Institute for Health and Care Excellence the was being followed. Speaking to GPs, patients experiencing mental health problems were having blood tests and mental health care plans agreed.

Management, monitoring and improving outcomes for people

The decision was taken to review patient records, as a result of concerns from data and information received during the inspection, about the assessment and annual reviews for patients with diabetes seen at the practice. The GP, on the inspection team, reviewed the records of five patients with diabetes, who had been to the practice in the past three months. We saw comprehensive assessments of care and treatment were in place and support provided to enable people to self-manage their condition.

The practice nurse took us through how reviews were carried out for patients with diabetes or asthma and provided us with examples of the detailed consultations which resulted in a self-management plan for patients which were recorded in an accessible format for patients to take away.

Are services effective?

(for example, treatment is effective)

We noted the practice was proactive in contacting patients who had missed annual reviews, to ensure they attended appointments. We saw one example of a patient being contacted four times before they attended the appointment.

We spoke with three GPs, including a registrar (GP in training) the practice nurse and two health care assistants. The practice nurse told us they valued having new 24 hour blood pressure monitoring equipment. This enabled them to make more informed clinical judgements and arrange timely investigations and support patients to manage their own condition.

The practice carried out audits to monitor patient experience, quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of audits and spoke with the lead GP to identify changes which had taken place in light of the audit outcomes. We saw actions were recorded and any changes which resulted from the audits were shared with staff through meetings and email correspondence.

Staffing

Speaking with staff and reviewing training records we saw all staff including locum GPs were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice.

There was an induction programme in place and mandatory training, for all staff including locum staff. The GP registrar told us they had a two week induction in which they spent time with all members of the team, and time with GPs going through policies, procedures and patient pathways.

The practice had a system for supervision and appraisal in place for all staff, and revalidation of doctors. All staff we spoke with confirmed they had participated in annual appraisals and were happy with the support they received from the practice. The GP registrar confirmed they received weekly supervision and a daily de-briefing session where required.

Staff told us they were able to access training and received update training on a regular basis, with time allocated for staff to participate in training on a weekly basis. We saw a comprehensive training programme was in place covering a range of mandatory and non mandatory subjects

Working with other services

We found that GPs, nurse and health care assistants at the practice worked closely as a team, and with other providers including the learning disabilities community team. Patients could be referred to community services such as smoking cessation and weight management.

We saw a protocol for shared care was in place and the practice worked to the gold standards framework for end of life care, with multi-agency meetings scheduled monthly. A podiatrist held clinics at the practice fortnightly for patients. A midwife held antenatal clinics twice weekly and a health visitor was available to provide families with children under five years old with support and advice.

Details of out-of-hours consultations patients had attended were shared with practice by the out of hours provider Go to Doc each morning before 8:30am, these were reviewed by a GP and where follow up action was required this was allocated to the GP on-call. The practice ensured the handover of information to the out of hour services with information for patients with long term health conditions or in receipt of any palliative care to ensure continuity of care out of hours.

Health Promotion & Prevention

The practice did not routinely provide new patients with health checks. New patients were required to complete a registration form and a health questionnaire which provided the practice with an overview of patients care and treatment needs whilst waiting for medical records from their previous GP to arrive. Patients had the option to request a health check. The practice website provided new patients where English was their second language with translated factsheets on the role of GPs and right to access NHS services. The practice website had a wide range of health promotion information and links to local and national organisations patients could access.

Written information was available for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion. We saw other patient information which included sexual health information, alcohol management, weight management and smoking cessation. There was also a wide range of information for patients who were carers, with local support services identified.

Are services effective?

(for example, treatment is effective)

Speaking with staff they provided us with a range of examples where they actively promoted healthy lifestyles during consultations. Staff told us of the range of services they could refer patient to both within the practice and the community.

Information was available for young people on a range of issues including bullying, abuse and sexual health. Young people were able to access condoms from the practice nurse without an appointment; ensuring young people had timely access to contraception and safer sex advice.

Are services caring?

Summary of findings

The service was caring. Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. We saw staff being helpful and sensitive to patient's needs. All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff we spoke with were able to explain to us how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision.

Our findings

Respect, Dignity, Compassion & Empathy

We observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs. We observed one patient attending without an appointment, and they were given an appointment for the same morning.

We spoke with 13 patients who were attending the practice on the day of our inspection and reviewed 26 comment cards received the week leading up to our inspection. All were positive about the care and treatment they had received from staff. One patient we spoke to told us: "They explain options and tell you what is happening." Another patient told us: "I've had very positive experience. I think highly of doctors and staff and I have built up a relationship with the GPs. I would recommend to a friend."

A minority of patients told us of a lengthy wait for appointments with a GP of choice or for routine appointments which were not emergencies. However all patients told us in emergencies they or family member were seen on the day wherever possible.

We observed staff speaking with patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Any phone calls received which required personal information were transferred to the office, to protect confidentiality. The office manager told us where patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms.

Patients we spoke with described being treated with respect and dignity when using the service. One patient told us: "GPs generally treat you with respect and they explain things clearly and give you options." The feedback received through the comment cards reflected the positive comments received from patients on the day. One person commented: 'Whilst receiving care and treatment I was at all times treated with respect and dignity. I felt listened to and understood I feel like I was given the treatment suitable for my symptoms.'

We found all rooms were lockable and there were appropriate screens in place to maintain patient's dignity and privacy, whilst they were undergoing examination or

Are services caring?

treatment. Staff explained to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity.

Involvement in decisions and Consent

The practice had a confidentiality statement, which included information for young people under 16 on their rights to confidentiality. A consent policy was in place which set out clearly how consent should be obtained and recorded. The policy clearly states a patient should understand a proposed treatment, immunisation or investigation before they are able to consent.

The policy included information about the patient's right to withdraw consent and made reference to Gillick competency when assessing whether young people under sixteen are mature enough to make decisions without parental consent for their care. Gillick competencies allow professionals to demonstrate they have checked the persons understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment using a recognised tool to record the decision making process. We were shown a template within patients records which staff were required to complete to ensure young people had been assessed for capacity to consent. We were shown forms for which consent other than implied consent would be recorded, this consent form, once signed would be scanned into patient's notes.

Clear policies and procedures were in place for staff to ensure appropriate action was taken where people did not have the capacity to consent. The policy was in line with the Mental Capacity Act 2005. The policy gave guidance for staff if patients with capacity wished to make an advanced directive. These enabled adults with capacity to make provision for a time when they might lose capacity, this can include an advance decision of refusal of life-sustaining treatment.

All staff we spoke with understood the principles of gaining consent including issues relating to capacity. We were shown an example of alerts for staff within patient's notes, which highlighted where people were unable to give consent to treatment, and provided details of advocates or a relative who were able to act in their best interest. The safeguarding lead told us, where they had concerns about a patients capacity, they would refer for a formal capacity assessment, and depending on the situation assessments were carried out within four weeks or two days if necessary.

Staff explained how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision. We were provided with examples of how people with learning disabilities were supported by advocates and or the community learning disability team, and extra appointments made to ensure that patients fully understood the condition and were able to take a role in managing their treatment with support. Another example provided was for a new patient for whom English was a second language, longer appointments were arranged to allow time for interpretation to take place and for the patient to understand treatment options.

The patients we spoke with confirmed that they had been involved in decisions about their care and treatment. One patient told us: "The GPs are very good and give you time, they explain things and tell you what is happening."

We saw patients had access to a chaperone service when they underwent an examination. Information was displayed in the waiting area informing patients of the service and how to request a chaperone during an examination. Staff acting as chaperones had received training. Provision of a chaperone helped to provide protection to patients and clinicians during sensitive examinations.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs. The practice had an understanding of their patient population, and responded to meet people's needs. The service asked for patient feedback on an annual basis, and a suggestion box was available in the reception area. We saw evidence of changes that had taken place as a result of input from patients. There was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found complaints were fully investigated with actions and outcomes documented and learning shared.

Our findings

Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

The practice population being 98% White British and practice had information in different languages, accessed via the website. The practice also used telephone interpretation services. We were told this service was accessible and provided a full range of language interpretation in a timely manner. The practice nurse described how this service had been integral to providing safe care and obtaining informed consent from patients. Extended appointments were provided for people who required interpretation. The practice was aware of an increasing Eastern European patient population that was registered with the practice and were looking at ways to ensure they were meeting people's needs.

The practice was proactive in making reasonable adjustments to meet people's needs and staff. Patients we spoke with provided a range of examples of how this worked, such as accommodating home visits, providing extended appointments where necessary and arranging appointments at times convenient to patient's needs. One relative told us: "My Husband has memory problems and staff write things down for him which is excellent." Another relative told us: "My wife had pneumonia last year and they bent over backwards when it happened and visited her at home."

We were provided with examples of additional support provided to patients with learning disabilities, this included multi-agency working and providing extended and more frequent appointments. For patients with long term conditions such as chronic obstructive pulmonary disease (COPD) were provided with extended appointments for the reviews, to ensure adequate time was available.

We saw where patients required referrals to another service these took place in a timely manner. Referrals were comprehensive and outlined the reason for the referral. Referrals and appointments with other services were followed through and tracked. The majority of patients we spoke with told us they were happy with the referrals made. One patient told us: "I was referred for treatment and it went very well." A relative told us: "We got a quick referral for our son to the hospital."

Are services responsive to people's needs?

(for example, to feedback?)

The practice were responding to meet local needs by introducing a range of services for patients within the practice such as minor surgery and anticoagulation service (a monitoring service for patients who are taking medication to reduce the risk of blood clots)

A repeat prescription service was available to patients; the practice manager told us of recent improvements to the system that had reduced the number of missed repeat prescriptions and complaints from patients. We saw an effective system was in place, with a collection from local pharmacists taking place for patients who had prescriptions delivered or collected directly from pharmacists. Patients we spoke with were happy with the system, with a number commenting on the convenience of accessing repeat prescriptions via the website.

Access to the service

The practice was accessible for people with mobility difficulties; with a spacious waiting area. The consulting rooms were all on one level, and rooms in the main were large with easy access for patients. There was also a toilet for disabled patients. A hearing loop was available and in use for people with hearing problems. Patients had a choice to see either male or female GPs.

The practice was responding to patient feedback in relation to accessing appointments, following an audit and patient feedback. One GP partner told us patient access was improving and they identified that no patients were turned away if they required an emergency appointment. This was corroborated by a recent audit of appointments. They told us access remained high on GP partners agenda to regularly review, and they were looking to introduce a triage system. Patients we spoke with were mainly happy with the appointment system; however concerns remained about the length of time to get an appointment with a

named GP, or for routine appointments. We observed reception staff working hard to provide patients with the earliest possible appointments and accommodate people's preference of GP, where alternatives were available these were offered to patients to ensure they were seen.

Home visits were available for patients. Health care assistants carried out home visits twice weekly. This ensured patients who were housebound had access to a range of services provided by the practice in a timely manner.

The practice had a clear, accurate and up-to-date practice leaflet containing information about services provided, and had a website, which provided a wide range of information on services provided and links to local and national organisations which provide support. Information was clearly available for patients on how to access the out-of-hours service.

Concerns & Complaints

We saw there was a complaints procedure in place. We reviewed complaints made over the past twelve months and found complaints were fully investigated; with actions and outcomes documented and learning shared with staff through team meetings.

Complaints leaflets were available to patients in the waiting area and displayed on notice boards. The information was also available on the practice website; despite this many of the patients we spoke with told us they would not know how to make a complaint.

The practice had a robust system in place to investigate concerns. We reviewed the log of concerns recorded over the past twelve months and found these were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

Are services well-led?

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

Summary of findings

The practice was well led. Staff described a service which was 'supportive and open to learning', providing staff with training and professional development opportunities. Systems were in place to identify, assess and manage risks related to the service provided through a series of internal checks and audits.

Our findings

Leadership & Culture

Staff told us they worked in 'an open and supportive environment to work'. Comments from staff included: "Support is very good, very supportive and really good when I needed support with personal circumstances, I can go to my mentor anytime, or pop in to see one of the GPs if I need anything." "It is very good here, very supportive, I never feel like I am bothering anyone." "I love it here, support by line manager, informal one to one when needed, their door is always open."

Staff told us they would have no hesitation to speak to senior staff if anything was troubling them as they knew they would be supported, and where appropriate action taken.

We found the service had in place a mentor system for staff and facilitates learning opportunities for staff internally and externally on a weekly basis.

The practice had a mission statement, which was available to patients and staff. Observing staff and speaking with staff and patients we found the practice clearly demonstrated a clear commitment to compassion, dignity, respect and equality.

Governance arrangements.

We found the practice had systems to assess and monitor quality. Staff had access to a range of policies and procedures which were kept up to date. We looked at several of the policies and saw that they were comprehensive and covered a range of issues such as medicines management, complaints, safeguarding and business continuity. The policies and procedures were available to staff on line and staff told us that any changes were notified to them via email.

Systems to monitor and improve quality & improvement

The practice manager had clear management systems in place to monitor the quality of the service provided and met weekly with the partners to monitor quality and discuss emerging issues. Systems were established to identify, assess and manage risks related to the service provided through a series of internal checks and audits, these included risk profiles, infection control, call answering and maintenance.

Are services well-led?

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

Weekly partnership meetings were held and minuted. During these meetings practice management, risk, significant events, and complaints were discussed and action agreed.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. There were systems in place to monitor services and record performance against the quality and outcomes framework. GPs were actively involved with the Clinical Commissioning group and had representatives on the medicines management group.

Patient Experience & Involvement

Feedback was sought from patients through an annual survey. Feedback from the survey was overall positive. The results were available for patients to see on the practice website and on notice boards within the waiting area. We saw action had been taken to address issues which had been raised from the survey. The annual survey was on going for 2014, patients were able to complete the survey on-line, but to date only five patients had completed the survey. Paper copies were to be provided for patients to complete in the waiting area. Patients were also able to provide feedback via the suggestion box in reception.

We saw there was a robust complaints procedure in place, with leaflets and details available for patients in the waiting area and on the website.

The practice had a newly established patient participation group (PPG) with three people currently involved. Posters were displayed in patient waiting areas to encourage more patients to join and information was available on the website. We spoke to one representative of the PPG who told us: "People don't always know the process or how to complain, and the problems of passing on information. That's what I see is the point of the PPG to inform people." The practice manager intended to develop the PPG to actively involve patients in the planning and development of people's care.

Staff engagement & Involvement

Staff meetings were held between the office and reception staff with the practice manager at regular intervals. Staff were able to influence the agenda items discussed. Regular formal and informal meetings were held between the practice nurse and health care assistants. These meetings regular incorporated updates and learning.

Learning & Improvement

The practice had a clinical audit system in place to continually review the service and deliver the best possible outcomes for patients. We saw a range of clinical audits and reviews had been completed, these included review of A&E attendance, review of colonoscopy referrals (A colonoscopy is an examination of the lining of the bowel wall), asthma audit, IUD (intrauterine device a contraceptive coil) audit and usage of medication. Outcomes of audits were documented and changes required to improve patient experience and outcomes were implemented. Audits were a regular agenda item to be discussed at partners weekly meeting and learning disseminated to staff via training update, staff meetings and internal emails.

We saw evidence of learning taking place from significant events and complaints. One example of a patient who left the practice and was subsequently diagnosed with diabetes. A formal review took place, which resulted in new protocols for blood tests being implemented to ensure appropriate investigations were carried out, where people may be at risk of diabetes.

We were told that all staff were provided with regular 'mandatory' e-training and training specific to their roles. They also had access to a range of training opportunities based upon their personal and professional development needs, with the nurse and health care assistants having access to regular updates from the hospital.

We looked at the training records for both clinical and non-clinical staff. The records showed that staff were provided with a range of training which the practice identified as mandatory. This included training in areas such as: confidentiality, basic life support, infection control, conflict resolution and equality and diversity.

We saw staff had access to additional training as part of their professional development. Staff told us they were able to request training and were supported to undertake professional development. The practice nurse told us they had been supported to complete their nurse prescribing course, and one GP told us they had access to study leave to develop leadership skills.

Are services well-led?

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

Identification and Management of Risk

We saw that health and safety risk assessments were in place. They clearly stated the nature of the risk and what measures had been put in place to minimise the risk in the future. Where further action to minimise risk had been identified we saw that this had been actioned.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines contained in GPs bags used for home visits.