

Dr's Brear, Wimborne and Fleet

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Dr's Brear, Wimbourne and Fleet, also known as York Bridge Surgery, on 14 October 2014.

We inspected this practice as part of our new focused, comprehensive, inspection programme. This practice had not previously been inspected.

The practice required some improvements and was rated as requires improvement overall.

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns, and reported significant incidents. When things went wrong reviews and investigations were carried out. The practice had identified that their identification of actions and review of these incidents could be improved and had developed a new reporting form to aid this.

- National Institute for Health and Care Excellence (NICE) guidance was used routinely. Staff had mostly received training appropriate to their roles. Staff appraisals and personal development plans were up to date.
- Patients told us they were treated with compassion, dignity and respect. However patients also said they could be overheard at the reception desk and this, we observed, as breaches of confidentiality when patients were at the reception desk.
- Some patients told us it was difficult to access appointments and to get through on the phone, with some telling us they had to wait up to a month to see a GP if they had a non-urgent problem. However, we received CQC comment cards which indicated that the telephone system had recently improved.

We saw areas of outstanding practice:

Summary of findings

- The practice met regularly to discuss which patients had recently passed away in order to identify and offer their families support. Bereaved families were visited at home to offer emotional support and to sign post to other services.
- The practice ran appointments in conjunction with Inspire (drug support agency) specifically for people with drug or alcohol problems. This encouraged people living chaotic lifestyles to attend the practice for health care and treatment.

However there were areas of practice where the provider needed to make improvements.

Importantly, the provider must:

- Ensure that staff are recruited and employed safely. The provider is failing to meet Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

In addition there were areas where the provider should make improvements:

- Policies, including safeguarding, whistleblowing, recruitment and the storage and handling of vaccines were not always up to date and appropriate to the practice.
- Safety checks and audits such as legionnaires, electrical safety and infection control were not actioned appropriately.
- Mental Capacity Act (2005) and "best interests" decisions was not included in staff training.
- Confidential information was disclosed at the reception desk and could be heard by people in the queue or speaking at the same desk.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns and reported incidents appropriately. When things went wrong investigations were carried out. The practice had identified the need to improve their system regarding actions and reviews of these incidents.

Two GPs took the position of safeguarding lead and deputy. Staff were knowledgeable about what constituted a safeguarding concern and knew which agency to refer to.

However, recruitment checks for non clinical staff did not demonstrate that staff were recruited safely. Two staff who were trained to provide chaperone services had not been checked by the Disclosure and Barring Service nor had references or proof of ID been obtained.

Systems in place had failed to identify that many staff policies did not reflect current guidance, and safety checks such as legionnaires risk assessment and electrical safety checks were not in place or out of date.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Care and treatment was delivered in line with current published best practice. The team used staff meetings and audits to assess how well they delivered the service.

The practice was a teaching practice and supported trainee GPs. GPs told us this encouraged discussion of new best practice guidelines. Annual staff appraisals were offered to staff to review performance and identify training or development needs for the coming year.

Good



Are services caring?

The practice is rated as good for providing caring services. We received 19 CQC comment cards and spoke with five patients. Patients were very positive about the care they received at the practice. They commented on the friendliness of the staff team and the competence of the GPs and nurses.

Good



Summary of findings

The practice had identified the importance of providing patients with privacy. The current reception arrangements however did not support this. A separate room was available for patients to speak to staff away from the reception desk.

The national GP survey results published in 2013 found that 84% of patients said the last time they saw or spoke to their GP the GP was good or very good at treating them with care and concern.

Are services responsive to people's needs?

The practice is rated as requiring improvement for providing responsive services. The practice made adjustments to meet the needs of patients, including having a portable audio loop system for patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients where English was not their first language.

The practice sought to gain patient feedback and had an active patient participation group (PPG). However, some ongoing issues raised by the PPG, NHS choices and patients we spoke to on the day of our inspection continued to be unresolved.

The practice had a complaints policy which provided staff with clear guidance on how to handle a complaint and we saw the documentation to record the details of any concerns raised and action taken. Complaints were handled appropriately however there was no documented evidence to show complaints were analysed for recurrent themes.

Requires improvement



Are services well-led?

The service is rated as good for providing well-led services. The practice had a clear vision and set of values which were displayed by staff and included a commitment to involving patients in their own healthcare.

GPs, clinical staff and the practice manager led on the individual aspects of governance such as complaints and audits within the practice.

Good



Summary of findings

What people who use the service say

We received 19 CQC comment cards. Each comment card gave positive feedback about the care provided by practice. However some commented that they found the appointment system to be a problem. The five patients we spoke with on told us they found this to be the case for routine appointments. Either they could not get through on the telephone or they could not get an appointment for weeks at a time. However, some CQC comment cards noted that this had recently improved and most people told us they could see a GP the same day if they had an urgent need. Patients did tell us that where their need was urgent that they could generally access same day appointments.

The 2013 national GP patient survey results found that 84% of patients said the last time they saw or spoke to their GP the GP was good or very good at treating them with care and concern.

We spoke with five patients who were all extremely positive about the care and treatment they received from the clinicians at the practice. Patients commented that they felt listened to and were treated with respect by both the reception staff and clinical staff.

Areas for improvement

Action the service **MUST** take to improve

Ensure that staff are recruited and employed safely. The provider is failing to meet Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

Action the service **SHOULD** take to improve

- Policies, including safeguarding, whistleblowing, recruitment and the storage and handling of vaccines were not always up to date and appropriate to the practice.

- Safety checks and audits such as legionnaires, electrical safety and infection control were not actioned appropriately.
- Mental Capacity Act (2005) and "best interests" decisions was not included in staff training.
- Confidential information was disclosed at the reception desk and could be heard by people in the queue or speaking at the same desk.

Outstanding practice

- The practice met regularly to discuss which patients had recently passed away in order to identify and offer their families support. Bereaved families were visited at home to offer emotional support and to sign post to other services.
- The practice ran appointments in conjunction with Inspire (drug support agency) specifically for people with drug or alcohol problems. This encouraged people living chaotic lifestyles to attend the practice for health care and treatment.

Dr's Brear, Wimborne and Fleet

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP, a Practice Manager specialist advisor and a second CQC inspector.

Background to Dr's Brear, Wimborne and Fleet

Dr's Brear, Wimborne and Fleet provide a service to 7160 patients in the North Lancashire area and are part of NHS Lancashire North Clinical Commissioning Group.

Public Health England figures show that 21.7% of all patients at this practice are over 65 years of age and are the largest percentage of the practice population. 20.8% of patients are aged under 18 years of age. The highest proportion of age groups registered with the practice.

The practice is open Monday to Friday between 8.30am and 6.30pm except on Thursdays when the practice is closed until 9.30am for staff training. The practice also operates extended opening hours. These are available on alternate Mondays when the practice opens at 7am, alternative Wednesdays when the practice closes at 8pm, and one Saturday a month when the practice is open between 8am and 1pm. The practice are currently also part of a pilot scheme involving four other local GP practices which offer extended access to GPs until 8pm every weekday and from 8am til 8pm on Saturdays and Sundays.

When the practice is closed and in the out of hours (OOH) periods patients are requested to contact either 999 for emergencies or telephone 111 for the OOH service provided by Bay Urgent Care. This information is available on the practice answerphone system and practice website.

The practice has five GPs, three male and two female, one Nurse Practitioner, two Practice Nurses, three Healthcare Assistants, and a pharmacist. The practice also has a practice manager and staff all are supported by administration, reception and secretarial staff.

The practice is a training practice and regularly has medical students. Other clinics are held at the practice. This includes a midwife's clinic, phlebotomy service and clinics for specific conditions.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care 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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 October 2014. During our visit we spoke with a number of staff and spoke with five patients who used the service. We reviewed 19 CQC comment cards where patients shared their views and experiences of the service.

We observed staff interacting with patients in the waiting area, spoke with staff and some patients and reviewed a number of documents that the practice used to ensure the smooth running of the service.

Are services safe?

Our findings

Safe Track Record

Information from NHS England and the Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety.

The practice encouraged all staff to report significant incidents. These were discussed at regular staff meetings and staff told us there was an open and transparent environment which encouraged staff to report any concerns. The minutes of these meetings were not detailed. Whilst we could see the event had been analysed, actions had not been assigned and reviewed. The practice had recently developed a new form to ensure this was addressed and a full cycle was in place. We were also told this would allow significant events to be analysed from a central log.

There were mechanisms in place using different information sources to ensure a shared awareness of key risks with all staff. For example, systems were in place to manage national patient safety alerts in order to protect patients. GPs received alerts by email. The practice pharmacist also produced and circulated an analysis of any alerts received relating to medicines.

We saw that that any complaints were investigated appropriately. However we did not see any documented analysis of the subject of these complaints which would identify any commonly occurring themes.

Learning and improvement from safety incidents

The Practice had a system in place for reporting and recording significant events. Staff told us that they were encouraged to report incidents and this was seen as a positive way to ensure they provided a high standard of patient care.

Safety alerts from Medicines and Healthcare products Regulatory Agency (MHRA) and other sources were monitored and shared with clinical staff via the internal email system and acted upon as necessary.

We found that changes to national guidelines, practitioner's guidance and any medicines alerts were discussed and actioned. Staff met on a regular basis

through a variety of clinical and non clinical meetings. This information sharing meant the GPs, nurses and non-clinical staff were confident the treatment approaches adopted followed best practice.

We saw that these meetings were minuted. The practice manager told us they would produce agendas for staff meetings to ensure key information was discussed routinely. This would further minimise the potential of misinformation, misunderstanding or error.

Reliable safety systems and processes including safeguarding

Staff we spoke with were knowledgeable about child and adult safeguarding. A hard copy of the local authority referral pathway and contact details were available in all treatment and consulting rooms and behind reception. The Staff we spoke with had a good understanding of safeguarding and told us how information was recorded on patient notes if a safeguarding concern was raised.

The practice had a named GP who took the lead role in safeguarding adults and children. A deputy was available in their absence. Staff had received training in safeguarding vulnerable adults and children which was appropriate to their roles.

Practice policies were in place and readily accessible to staff. However, despite being recently reviewed, these policies did not reflect current guidance. For example the safeguarding children policy referred to the previous commissioning organisation, the Primary Care Trust, and the contact number was out of date.

Staff monitored children who frequently missed appointments. These children were brought to the attention of the GP who told us they would inform other health professionals such as the health visitor.

Staff we spoke with understood what was meant by the term Whistleblowing and the practice had a policy in place. This meant there were processes in place to assist staff to expose poor care or bad practice. However, staff were unaware they could contact the Care Quality Commission about such concerns and this was not mentioned in the practice policy.

Notices were displayed in treatment rooms advising patients they could have a chaperone present during their consultation if they wished. The practice had a chaperone

Are services safe?

policy in place. Clinical staff were used to act as chaperones. Two further reception staff had received relevant training to allow them to provide this service in the absence of clinical personnel.

Each consultation and treatment room had a panic button which could be used by staff to summon assistance in an emergency.

We saw documentary evidence the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. Staff had completed training on fire safety as part of their induction with further annual reviews and they were aware who the practice fire marshal was.

Medicines Management

Medication reviews were conducted by GPs or the practice pharmacist. The practice checked patients receiving repeat prescriptions had an annual medicine review. For patients with long-term conditions, such as diabetes, there was a system in place to ensure regular health checks took place.

The medicines fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed and rotated.

We found that the vaccine fridges were not hardwired which is considered to be best practice according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014. Fridges which are hardwired directly rather than having a conventional plug reduce the risk of the fridge losing power.

We were informed of a recent incident where the fridge had lost power and vaccines were disposed of. Following our inspection the practice provided evidence that this was treated as a significant event. However the analysis of the event had not identified they had not followed relevant protocols for the correct disposal of vaccines and there was no evidence that learning had been achieved. The practice policy for the storage and handling of vaccines also required updating.

Oxygen was readily available in the practice. We saw that staff could access the oxygen and the cylinder was full, in date and ready for use.

Cleanliness & Infection Control

We found the practice to be clean and tidy and patients we spoke with confirmed this was always the case.

There was a waste collection contract in place to collect clinical waste on a weekly basis.

Personal protective equipment (PPE), such as aprons and gloves, was available in all treatment rooms. Staff we spoke with told us these supplies were always well stocked.

Clinicians were responsible for ensuring infection prevention and control standards were maintained between patient appointments. The practice had an infection prevention and control policy in place. The Nurse Practitioner was the appointed lead for infection prevention and control. We saw that audits had been conducted and actions identified. However, we saw actions were not addressed and were reoccurring on subsequent audits. For example, the acquisition of elbow taps and wipeable seating had been identified. However these were repeated as an action on the next audit. There was no action plan in place to replace these items.

The staff policy stated all staff received yearly infection control training. However records showed only the nurse had received this training. Following our inspection evidence was provided that other staff had only been trained in hand hygiene.

We found the legionnaire risk assessment was out of date. This had not been identified by the practice.

Equipment

There was a contract in place to check that medical equipment was calibrated to ensure it was in working order. The practice also had contracts in place for portable appliance tests (PAT) to be completed on an annual basis.

The practice had a defibrillator which ensured they could respond appropriately if a patient experienced a cardiac arrest. Staff told us that they were trained to use this equipment. Emergency equipment including oxygen was readily available for use in the event of a medical emergency.

A blood pressure monitor was available in reception for patients use. Patients were encouraged to present the result of this to the reception team who forwarded the results to the nurse for analysis and follow up.

The practice had a gas safety certificate in place, however we were informed that an electrical safety certificate had not been obtained.

Staffing & Recruitment

Are services safe?

The practice had a policy for the safe recruitment of staff which included guidelines regarding seeking references and proof of identity as well as obtaining criminal record checks for all staff. The policy made reference to the old system as opposed to the new DBS (Disclosure and Barring Service) checks. When we checked a random sample of staff files we found the relevant checks had been carried out for clinical staff. However two staff members who were trained to act as a chaperone did not have a DBS certificate. There was also no evidence of references or proof of ID for these staff members.

There was a system to monitor staff training. Practice managers had an oversight of this but encouraged staff to take responsibility to highlight any areas where training was needed.

We found that clinical staff registration with their respective professional bodies was checked on an on-going basis and the practice held proof of medical indemnity insurance. We saw evidence that these checks were recorded yearly.

Monitoring Safety & Responding to Risk

The practice team had agreed the requirements for safe staffing levels at the practice. Staff worked regular sessions or agreed set hours and set days each week to consistently maintain the service provided. On the day of our inspection there was a vacancy for a salaried or partner GP.

We were told that locum GPs were rarely used at the practice and there was struggle to source them when they were required. We were told the practice had suffered a turbulent year due to factors including staff sickness and new computer systems. We could see that new staff were being recruited and the new computer system was being embedded. Reception and administration staff, in the event of sickness or leave, supported each other by providing appropriate cover amongst the remainder of the staff. Three new members of reception staff were due to begin the week following our inspection.

GPs and Nurses took lead roles for example in palliative care, infection control and safeguarding adults and children.

An extended hours service was available to meet the needs of the working population. Alternate Mondays when the practice opened at 7am, alternate Wednesdays when the practice closed at 8pm, and one Saturday a month when the practice was open between 8am and 1pm.

At the time of our inspection the practice were also part of a pilot scheme involving four other local GP practices which offer extended access to GPs until 8pm every weekday and from 8am til 8pm on Saturdays and Sundays.

Emergency appointments were also available each day.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan in place which was accessible on the practice computer system and given to staff on induction. This covered plans for a number of potentially disruptive events. Staff knew how to find this guidance and were knowledgeable about what to do in the event of an emergency.

All emergency equipment was regularly checked and readily available for staff to access in an emergency.

Regular maintenance checks were conducted on the oxygen cylinder. Nurses also checked emergency medicines and the vaccine fridges.

Each consultation and treatment room had access to a panic alarm which could be used to raise an alert to all other members of staff if assistance was required. One staff member told us this system worked well when they recently had cause to use it.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that the practice followed national strategies relating to caring and treating patients. For example people aged over 75 years of age had a named GP. The practice kept up to date registers for patients with long term conditions such as asthma and chronic heart disease and patients completed annual health reviews.

The GPs and nursing staff could clearly outline their rationale for approaches to treatment. They were familiar with current best practice, accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with clinical staff that they completed assessments of patients needs in line with NICE guidelines and these were reviewed when appropriate.

Clinical staff told us how they accessed best practice guidelines to inform their practice and clinical staff met regularly to share these updates. The practice was a training practice, which, we were told, encouraged learning not only for trainee GPs but on-going learning for senior doctors.

The patients we spoke with told us they felt they received care appropriate to their needs. Most told us they were involved in discussions about their care and treatment and where choices were available they could make their own decisions with support from the GP.

Care plans had begun to be introduced for vulnerable patients such as those nearing the end of their life. These patients had access to a direct contact number to the practice mobile which was manned throughout the day.

Management, monitoring and improving outcomes for people

The Practice has a system in place for completing clinical audit cycles. We saw examples of these including an audit of patients prescribed the benzodiazepine 'Temezepam' due to the associated long term effects of this medication. We saw evidence of completed audit cycles and direct health benefits for patients.

The patients we spoke to who had long term health complaints confirmed they received regular health reviews and were called by the practice to arrange these. We saw evidence of these systems in the practice.

The practice provided a regular clinic for those patients prescribed anticoagulation medications. Patients we spoke with who accessed this clinic, and one patient who mentioned it on their CQC comment card, spoke highly of this service and commended this being available at their local practice.

The flu vaccination program offered at the practice was advertised throughout the waiting area and we heard patients on the phone and in the practice being encouraged to book in. The practice also sent reminder letters to those who were identified as at risk.

Effective staffing

The practice had policies and procedures in place to support staff in carrying out their work. For example, newly employed staff were supported and supervised in the first few weeks of working in the practice to help confirm they were able to effectively carry out their role. An induction programme included time to read the practice's policies and procedures. Staff, including trainee doctors, had easy access to a range of policies and procedures via the computers systems to support them in their work.

A training policy was in place and training included in-house and on-line training in the form of E-Learning. The mandatory training included annual fire safety, Cardiopulmonary Resuscitation (CPR) and child and adult safeguarding.

Most GPs were up to date with their validation, with one GPs scheduled. The practice offered annual appraisals to review performance at work and identify development needs for the coming year. Records confirmed annual staff appraisals took place.

Staff told us they received appropriate and effective support. Nursing staff told us they worked well as a team and had good access to support from each other and their GP colleagues.

There were a range of regular staff meetings. These meetings provided communication, support and learning opportunities.

Working with colleagues and other services

Are services effective?

(for example, treatment is effective)

The practice worked with other agencies and professionals to support continuity of care for patients. Information received from other agencies, for example, accident and emergency was read and actioned by the GP and scanned onto patients' records in a timely manner.

The practice staff worked with the local community nursing team, midwives, and health visitors. We found that the clinicians appropriately referred patients to community teams, for example pregnant women were seen for their ante-natal appointments by the community midwives. We were told that the practice sometimes struggled to engage the District Nurses in practice meetings but they hoped this would improve with a new team due to start shortly.

Patients we spoke with who had been referred to other services told us that the practice liaised well to keep them informed about their treatment.

We saw evidence that the practice participated in external peer reviews. Practice managers from local practices spent time at each other's location to identify good practice and recommend improvements.

Information Sharing

Information sharing took place appropriately, such as within multi-disciplinary team meetings, safeguarding adults and children, palliative care meetings and shared care such as hospital referrals and discharges and community team involvements.

Consent to care and treatment

Staff informed us they had access to interpreter services for patients who required this support. A portable hearing loop was also available for staff to assist patients with hearing difficulties.

Staff were aware of how to locate the practice consent policy, however this did not cover the Mental Capacity Act (MCA) and best interest decisions. There was no evidence that staff had received formal training, however the clinical

staff we spoke to were knowledgeable in this area. This legislation is a legal requirement that needs to be followed to ensure patients who are unable to give consent for certain aspects of their care and welfare receive the right type of support to make a decision in their best interest. We have since received information that practice staff have been offered training in this area from the Clinical Commissioning Group (CCG).

Capacity and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to ascertain and consider whether 'best interest' decisions for patients who lacked capacity were required and the nurse or GPs sought approval for treatments such as vaccinations from the child's legal guardian.

Health Promotion & Prevention

The practice supported patients to manage their health and wellbeing. The practice offered vaccination programs, long term condition reviews and provided health promotion information to patients. A variety of health promotion leaflets were available in the waiting area, including details of smoking cessation. Information was available to allow patients to make informed choices.

The practice also provided patients with information about other health and social care services such as carers support and advocacy services.

At the time of inspection the practice was promoting flu vaccinations. We saw a variety of promotion literature around the practice.

Staff were aware of a local initiative called Help Direct which we were told might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement. Staff were also aware of how to refer people to this service.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the results of the 2013 national GP survey. This showed that 84% of patients seeing a GP and 95% of patients seeing a nurse said they were treated with care and concern. However the practice score was below the CCG average for overall experience the percentage of patients who stated their of their GP surgery as fairly good or good. The percentage of patients who stated that in the reception area other patients could not over hear was a concerning 0%.

The staff we spoke with told us they took pride in providing good patient care. On the day of our inspection we saw patients were spoken to with respect and the patients we spoke to, and the CQC comment cards we received, commented on the friendliness of the staff team.

We considered the confidentiality in the reception and adjoining patient waiting area. A notice was displayed which advised patients that a separate room was available should they not wish to discuss matters at the reception desk.

However, when we observed the reception area during our inspection we found patients were huddled next to the reception desk so there was no privacy when speaking with a receptionist. We heard confidential information being discussed as patients stood side by side at the desk. The majority of the patients we spoke with told us they thought their conversations with a receptionist could be overheard. However, they said they were aware there was a private room available if they wanted to speak to a staff member in confidence.

Consultation rooms had lockable doors and privacy curtains. We saw that doors were closed during patients' appointments.

The computer system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, if the patient had a learning disability.

Patients told us they were given enough time during their appointments, and that GPs and nurses explained things to them in a way they understood.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 79% of patients said the GP involved them in care decisions, 94% of patients said the nurses did the same.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. We were told that if patients wished for a friend or family member to attend for support, that this was not a problem.

The practice had access to an interpreter service and staff were aware how to access this.

Patient/carer support to cope emotionally with care and treatment

Multi-disciplinary palliative care meetings were held on a monthly basis to discuss the needs of those approaching end of life. The practice also held regular meetings in-house to look at patients who had recently died and to offer support to their carers or relatives. We were told this included a home visit to offer support.

One patient told us they had been offered emotional support by the practice and commended the caring and empathetic way they had been dealt with. Patients told us they were usually treated in a caring way by staff at the practice. The CQC comments cards we reviewed also indicated patients received the necessary emotional support. For example one person said they are made to feel at ease and listened to. Another person said they are always treated with patience and respect.

The reception area contained information about how patients could access emotional support such as counselling. Information about how carers could access support was also given.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The patients we spoke with were happy with the care and treatment they received from the practice. Patients commented positively on the consultation, referrals and treatment provided.

We were told by clinical staff how the practice worked with patients to ensure they received the treatment they required. This included follow up phone calls to women who had not attended for screening appointments after reminder letters had been sent.

At the time of the inspection the practice was actively promoting flu immunisation. There were posters around the waiting area to draw this to the attention of patients.

The practice had an active patient participation group which was held virtually to encourage participation.

We received 19 completed Care Quality Commission comment cards and spoke with five patients. All were very complimentary about the care provided by the clinical staff and most noted the overall friendliness of all staff.

Each patient we spoke with and some people who responded on a CQC comment card told us that the system for routine appointments was a problem. We also saw various comments about this on the NHS choices website which reflected this had been a concern for some time.

One person told us they had to wait a month for an appointment. Whilst others commented on the amount of time it took to get through on the phone.

The practice told us they were aware of this problem and were beginning to try to address it. We saw that an action plan had been devised to address some of these issues. For example phone lines between the busy hours of 8am and 9 am had been doubled from four to eight. A newsletter had been produced to encourage patients to call in the afternoon for results and to use the online services to ease the burden on the telephone lines. Some CQC comments cards we received commented that the phone system had recently improved.

Three new members of reception staff were due to start the following week. There was also an outstanding vacancy for

a salaried or partner GP. We were told it was extremely difficult to find locum GP's to cover this deficit and most staff told us this vacancy was the main problem in the practice.

Appointments at the practice were usually for 10 minutes. Staff told us that where they felt a longer appointment would be beneficial, for example if a patient had a learning disability or if a patient was particularly anxious, this would be arranged.

The practice ran appointments in conjunction with Inspire (drug support agency) specifically for people with drug or alcohol problems. This encouraged people living chaotic lifestyles to attend the practice for health care and treatment.

The GPs attended palliative care meetings regularly to ensure the needs of their patients requiring palliative care were met. A health visitor attended the practice every six weeks. These meetings meant the practice could discuss ways of responding to the individual needs of patients. However, we saw various examples of actions being raised in these multi-disciplinary meetings, but not assigned which led to the same action point being raised at two subsequent meeting with no identified follow up.

Most people we spoke with told us the reception area was often overcrowded and commented that people could hear their conversation with receptionists. The GP patient survey response echoed these views as did the PPG survey conducted in March 2014. The practice had recognised these concerns and had an action plan dated August 2014 which identified how the reception areas would be improved. However there were no dates for completion and the work had not begun. We saw a further questionnaire dated September 2014 asking the patients their views again on this matter. However no remedial action had taken place to address this matter.

Tackling inequity and promoting equality

The new patient list was open and staff were able to offer appointments to patients, including those patients with no fixed abode. The practice was responsible for patients from the rehabilitation unit at the local NHS hospital. The majority of these patients had no permanent address.

Are services responsive to people's needs?

(for example, to feedback?)

Public Health England's data found that the practices average male life expectancy of 75.8 and female life expectancy of 80.6, compared to England's national average is 78.9 for males and 82.9 for females.

Clinical staff held a number of regular clinics at the practice to review for example chronic disease management, immunisation and vaccination and diabetes.

Staff were aware of how to access interpreter services but most staff said patients generally brought family members with them to translate. We asked the practice to consider the safety and suitability of this, for example, when obtaining consent.

The practice was aware of patients with a learning disability. A record was also kept of patients with caring responsibilities. Information was available in the reception area regarding support for carers and GPs were aware of local carers groups, referring patients where appropriate.

Access to the service

Patients with a physical disability were identified on the practice computer system. A disabled toilet and baby changing facility was available. The reception area was fitted with a hearing induction loop.

Same day appointments were available, and patients told us that if they had an urgent need they would be seen the same day. However, most people we spoke with told us it was extremely difficult to book routine appointments and could wait a month to be seen.

Home visits and urgent on the day appointments were available every day. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and on the practice website.

Patients told us they found it difficult to get through to the practice on the telephone. 21% of patients in 2013 GP survey said they found it easy to get through to the GP surgery on the phone. Much lower than the national average of 75%. The patients we spoke to told us this was still a problem, however some CQC comment cards stated this had recently got better.

The practice had patient consultation rooms on the ground floor only. All rooms were accessible for patients with mobility difficulties. There were large waiting areas. There was a car park at the practice and spaces were available close to the front door for patients with mobility difficulties.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. This was managed by the practice manager. We saw a summary of the eleven complaints that had been made to the practice in the 12 months prior to our inspection.

We saw these complaints had been handled and responded to appropriately. However the practice did not review complaints for trends in order to assess if there was a common problem. This would enable the practice to learn from incidents and implement changes to improve service provision

Complaints, concerns and suggestions were encouraged in the practice leaflet, in the waiting area and on the practice website.

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

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

GPs attended prescribing, palliative/supportive care meetings, safeguarding meetings and shared information within the practice.

Staff told us the various meetings helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback.

The practice policy in the practice leaflet reiterated some of the values we had seen portrayed by staff during our inspection. For example, patients being treated as a partner in the provision of their care and staff obtaining informed consent. Staff told us they were committed to providing a good service for patients.

Governance Arrangements

The staff we spoke with were clear on their role and responsibilities within the practice.

We found a number of policies required updating, including whistleblowing, recruitment, safeguarding children and adults and vaccine transport and storage. Although these had been recently reviewed the system in place to check their relevance was not always effective. The policies usually contained a date when they had been reviewed but no date was given for future reviews. There was no evidence that the policies had been fully embedded into the workings of the practice.

GPs had lead roles and took responsibility for a number of clinical areas. GPs were involved in training and supporting trainee GPs. Individual aspects of governance such as complaints, risk management and audits within the practice were allocated to appropriate staff, for example the practice manager held responsibility for the oversight of complaints. The practice submitted governance and performance data to the CCG.

We found that some systems had failed to identify potential problems, for example the legionnaire risk assessment was out of date and an electricity safety certificate had not been obtained.

Leadership, openness and transparency

We saw that there was a leadership structure in place. GPs took the lead for areas such as safeguarding, training, and minor surgery. Staff all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us they had the opportunity to ask questions during staff meetings, and they could approach the practice manager, who had an open door policy, at any time.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings we saw evidence that changes were implemented in most cases.

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

We saw from minutes of meetings that appropriate staff members attended and contributed to the running of the practice. Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered.

The 19 CQC comment cards received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained.

The practice had an active patient participation group (PPG) which was currently held virtually. We were unable to speak to any current members of the group on the day of our inspection. However we did see the practice actively promoted the group and one patient told us they were going to join. A report was produced in March 2014 based on the PPG response to what the surgery could improve. We could see the practice had actioned some points, such as extra telephone lines and a dedicated repeat prescription answer phone service.

Management lead through learning & improvement

Are services well-led?

Good 

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

Staff told us about how the practice learned from significant events and the improvements following any change implementation that took place. The practice had recently identified that their reporting form lacked information to ensure learning from events was correctly actioned and reviewed. We were shown a revised form which covered these points.

The practice partners and managers were supportive of staff's personal development and provided staff with extra support to achieve qualifications or experience which would increase the staff member's effectiveness and that of the service provided to their patients.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Reception staff told us they were informed when they needed to update their training. Some training was available on-line and some was provided by the practice during meetings.

We looked at a selection of staff files and saw that regular appraisals took place which included a personal development plan.

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	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The practice recruitment policy and processes are not followed. Staff files are inconsistently maintained and did not demonstrate staff are recruited and employed safely.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	