Mill Road Surgery

Quality Report

47 Mill Road
Mile End
Colchester
Essex
CO4 5LE
Tel: 0844 576 9445
Website: www.millroad-surgery.co.uk

Date of inspection visit: 5 June 2014
Date of publication: 13/08/2014

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 findings

Overall summary

Mill Road Surgery provides primary medical services for approximately 12,000 patients living in Colchester and the surrounding area, with the capacity to take 16,000 patients. The practice provides a pharmacy dispensing service. The practice was established as a GP and nursing training practice. The practice has not recently provided training to GP registrars, but is looking to resume this in the future. GP Registrars are fully qualified doctors who are training to specialise in General Practice.

We found from our inspection that generally patients were satisfied with the service provided to them at Mill Road Surgery. Patients mostly found that clinical and reception staff were pleasant and any issues were dealt with in a timely manner. Most people told us that they were treated with dignity and respect; the GPs requested consent appropriately and discussed any treatment options available.

We found the practice to be responsive to the changing needs of their patient population and proactive in putting plans in place for future changes.

There were systems in place for dealing with non-clinical emergencies.

Although the practice checked emergency medicines were available we found some were out of date. There were no formally documented checks to ensure that the emergency equipment was working. We also found that the systems within the practice for checking fridge temperatures were inadequate; although the systems in place in the dispensary for the same activity were robust.

There was an open culture within the practice which encouraged staff and patients to report incidents and concerns, and to suggest improvements. The GP partners and practice manager had a clear vision of the practice's principles and priorities.

The practice used clinical audits and dispensary audits, as well as best practice, to improve the outcomes for all patients.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that there were systems in place to monitor the safety of the service provided to patients and address any safety concerns that patients, their representatives or staff may have. Where issues were identified these were investigated and appropriate action taken to deal with the concern and ensure any learning was shared appropriately. Contingency plans were in place for non-clinical emergencies.

The practice had a robust system in place for the storage and disposal of medicines within the dispensary. Appropriate checks were carried out on staff before they commenced employment at the practice.

The practice did not have fully effective systems in place on the day of our inspection to ensure that emergency medicines and equipment were in date and maintained, or to ensure vaccinations were stored at the correct temperature. This was addressed immediately at the time of our inspection and following our inspection protocols for this were reviewed and systems put into place.

Are services effective?

The service was effective.

We found that the practice positively engaged and worked in partnership with other services to meet the needs of patients in a co-ordinated and timely way. All staff we spoke with told us that they felt supported. Training was in place to ensure patients were treated by skilled staff.

The practice had health promotion and prevention systems in place, and was effective at monitoring, managing and improving outcomes for patients.

Are services caring?

The service was caring.

People told us that generally staff treated them with respect and dignity. Consent was obtained and care and treatment discussed with patients in order for them to make an informed decision.

We saw examples during our inspection of patients being treated with respect, dignity compassion and empathy by staff.

Are services responsive to people's needs?

The service was responsive to people's needs.

Summary of findings

We found that the practice understood the demographic of its population and adjusted its resources to ensure patients' needs were met.

We found that there was timely access to clinical staff both for routine and urgent appointments. Where patients chose to attend A & E or walk-in services, it was not due to a lack of appointments at the GP practice.

There was an effective complaints system in place, with follow up actions evident, where appropriate.

Are services well-led?

The service was well-led.

Governance arrangements at the practice were clear and leadership was strong. The culture of the practice was open and staff told us they felt empowered to report any concerns or to make suggestions for improvement. Staff were encouraged to take ownership of their responsibilities. There was a strong focus on improving quality of care through learning. This was evident across all staff groups within the practice.

The practice was supportive of staff development and patients' views. Both staff and members of the patient participation group (PPG) told us that they felt supported and listened to. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. Staff were aware of the key risks to the organisation and had undertaken planning in order to address these risks.

Summary of findings

The six population groups and what we found

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

Older people
The practice was proactive in establishing links with other health and social care professionals so that when patients required it there was access to good co-ordinated care

People with long-term conditions
The practice had systems in place to monitor those with long term conditions and offer reviews as appropriate

Mothers, babies, children and young people
The practice had systems in place to offer co-ordinated care to mothers, babies, children and young people. Clinical staff were aware of consent and capacity principles and how to apply these.

Emergency medicines for children, for use in the event of a severe allergic reaction, were out of date.

The working-age population and those recently retired
The practice had reviewed its access hours to ensure the service was accessible to those patients of working age

People in vulnerable circumstances who may have poor access to primary care
Staff understood the needs of patients with learning disabilities and tried to support them in ways that would cause them the least distress.

The practice had a system in place to ensure that patients with learning disabilities were reviewed annually.

Although the practice did not have any homeless people registered with them a policy was in place to support access.

People experiencing poor mental health
The practice had systems in place to offer support to people experiencing poor mental health. Staff were trained to deal sensitively with patients presenting in crisis either on the telephone or in person.

Summary of findings

What people who use the service say

Before our inspection we arranged for patients to complete our comment cards asking for their views of the service provided at the practice. Feedback from 22 completed comment cards was very positive about the service provided and the staff. People felt the premises were clean, that staff were friendly and treated them with dignity and respect. Any concerns were dealt with quickly and to their satisfaction.

We spoke with 15 patients during our inspection. Their feedback was generally positive about the surgery and several said when asked that they would recommend the surgery to their family and friends. Three patients we spoke with felt that the attitude of the doctor that they saw could have been improved. We raised this with the senior partner who assured us that this doctor was popular with other patients. Patients told us that continuity of care was generally good. The majority of patients told us they were able to get an appointment when they wanted. Most patients told us that they were confident in the ability and training of staff, and that they felt safe, involved in their care and respected.

We spoke with staff from three care homes which the practice provided a service to. They were generally positive about the service provided and told us that where an emergency home visit was required these were completed in a timely manner. They told us that concerns were dealt with effectively. One service informed us that occasionally it could be difficult to get a same day appointment at the practice. The care homes told us that staff from the practice had a good understanding of the needs of their clients. These included people with dementia and those people with learning disabilities.

Areas for improvement

Action the service COULD take to improve

The standard operating procedures (SOP) for the dispensary although detailed could be personalised to the practice service.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was proactive in recruiting staff to anticipate future population needs.

The practice valued its staff and provided training above that required to enable them to complete their role. In doing this the surgery encouraged staff to develop their interests and to expand the types of service offered to their patients.

The practice had a tracker system in place to monitor the results of all imaging requests, for example, x-rays. The tracker system reviewed these requests after one month.

The practice had used available funds to make a counselling service available on-site. Where this facility had reached capacity external counselling was sought. Patients could be seen within one week of referral and in certain circumstances the same day.

Mill Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC inspector and a practice manager.

Background to Mill Road Surgery

Mill Road Surgery is a dispensing practice based near to Colchester Hospital. This means that patients may also obtain medication directly from the practice. The practice provides a primary medical service to patients from Colchester and the surrounding villages of Little Horkesley, Great Horkesley, Leavenheath, Nayland, Stoke by Nayland and West Bergholt.

Its population mainly comprises families with young children however more older people were registering with the practice than they had had on their registration list before. The area has low numbers of ethnic minority groups compared with the national average.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information: some information that we had requested from the practice, information we held about the practice and other information that was publically available. We also asked other organisations to share their information about the practice. We spoke with two care homes providing a service for people with learning disabilities and one care home for older people including those with dementia.

We carried out an announced inspection on 05 June 2014. During our inspection we spoke with a range of staff, including: doctors, nurse practitioners, nurses, reception

Detailed findings

staff and administration staff. We spoke with 12 members of staff in total. We spoke with 15 patients who used the practice including older people, working age, people with long-term conditions and mothers.

We spoke with two members of the Patient Participation Group (PPG) during our inspection. We had feedback regarding the practice from six members of the PPG prior to our inspection. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

We reviewed information that had been provided to us during the inspection and we requested additional information which was reviewed after the inspection.

A comments box with comment cards was left, by us, for approximately two weeks in the waiting area. We received 22 comment cards which we reviewed during our inspection in order to inform our judgements.

Are services safe?

Summary of findings

We found that there were systems in place to monitor the safety of the service provided to patients and address any safety concerns that patients, their representatives or staff may have. Where issues were identified these were investigated and appropriate action taken to deal with the concern and ensure any learning was shared appropriately. Contingency plans were in place for non-clinical emergencies.

The practice had a robust system in place for the storage and disposal of medicines within the dispensary. Appropriate checks were carried out on staff before they commenced employment at the practice.

The practice did not have fully effective systems in place on the day of our inspection to ensure that emergency medicines and equipment were in date and maintained, or to ensure vaccinations were stored at the correct temperature. This was addressed immediately at the time of our inspection and following our inspection protocols for this were reviewed and systems put into place.

Our findings

Safe patient care

Events that may affect patient care were identified and investigated in a timely manner.

We saw there were systems in place to report and record safety incidents and concerns. We found that the practice tracked their performance both overall and as a result of incident reporting and complaints. Where concerns were raised they were investigated and changes made, where possible, as a result.

Staff we spoke with were aware of their roles and responsibilities in reporting incidents relating to patient safety.

Learning from incidents

We found that the practice completed significant events analysis (SEA). The outcome of these would be discussed and disseminated amongst the other staff in the practice in order for lessons to be learned and improvements to be made. Where appropriate SEA would also be shared with relevant external agencies for example, district nurses and the local hospital. This open and transparent approach to sharing learning from incidents helped to inform the practice of professionals working across different organisations and supported the improvement of patient care.

We saw that when national or local safety alerts came into the surgery, relevant staff were made aware them. This showed that the practice took account of incidents that had occurred both internally and externally. The practice made sure that staff were aware of outcomes and where procedures/policies needed to be changed this happened.

Safeguarding

There was a GP safeguarding lead who was known to all staff. There were robust procedures in place to assess and identify potentially vulnerable patients. Staff we spoke with were aware of these processes and knew when to refer a patient to the social services safeguarding team.

The computer system used by the practice had a system to highlight to staff those patients identified as being in a vulnerable group. This included those on the safeguarding register and/or those on the mental health register, for example. We were told that GPs from the practice attended child protection meetings and all GPs were then made

aware of the outcomes. The electronic system used by the health visitors could be viewed by the practice so relevant information could be shared. This showed that staff were aware of the systems in place to protect vulnerable adults and children and that this information was shared appropriately with relevant health professionals.

Monitoring safety and responding to risk

Protocols were in place to ensure staff were able to handle urgent and emergency situations appropriately. Both reception and clinical staff were observed on the day of our inspection to recognise urgent situations and respond to them appropriately and sensitively.

We found that whilst patients were in the building there was always a GP available for emergency situations. All staff were trained in cardio-pulmonary resuscitation (CPR) and how to use emergency equipment. Reception staff were trained in call handling and in the event that a patient had chest pain or was excessively out of breath, they knew what action to take. We found that the computer and phone system incorporated an alarm which alerted all staff in the event of an emergency.

We found that the checks for ensuring that emergency equipment and medicines were in date and in working order were not robust. Whilst systems were in place to check medicines for use in clinical emergencies, these checks had not identified that some medicines and needles were actually out of date. There was no formal check system for the defibrillator although staff assured us that this was completed monthly. The practice took immediate action to address this on the day of our inspection and updated it's processes to try to ensure that the procedures surrounding the checking of vaccination fridges, emergency medicines and equipment were more robust.

Medicines management

We viewed the dispensary for this surgery (including checking stock and temperature checks of refrigerators), spoke with dispensary staff and looked at their standard operating procedures (SOP). We found this part of the surgery to be well organised with detailed SOPs. All dispensing staff were clear about their roles and policies and procedures. We viewed the systems around controlled drugs (CD) and found processes to be robust. Where CD errors had occurred these were minor and were well documented and followed up.

Cleanliness and infection control

People told us through comments cards and in person on the day of our inspection that they found the surgery to be clean. We saw that all areas of the surgery looked visibly clean. There was hand gel available for staff and patients to use at the entrance to the surgery.

We found that all staff completed infection control training at induction. There was comprehensive infection control policy/procedures and information in place, including National Institute for Care and Health Excellence (NICE) guidelines, which was accessible to all staff. There was a designated infection control lead within the surgery to provide support to other members of staff around infection control queries.

Cleaning was provided by an external company and checks completed by the practice manager. Nursing staff had individual responsibilities for cleaning clinical equipment and confirmed this was completed. The practice may find it useful to note that nurses cleaning of equipment was not formally documented therefore it would not be possible to check that it had occurred.

We saw that there were contracts in place for the management and disposal of clinical and domestic waste products and viewed the receipts to confirm this took place.

Staffing and recruitment

We viewed four staff files and saw that there were effective recruitment and selection processes in place. Appropriate checks had been undertaken before staff began work. People had been through an interview process to assess their suitability and experience for the role. We saw that Disclosure and Barring Service checks (DBS replaced the Criminal Records Bureau or CRB) had been carried out, references taken up and their identity checked. Through these strategies the practice aimed to ensure that only suitable and appropriately qualified staff were employed.

Dealing with Emergencies

The provider had a robust business contingency plan in place to anticipate any foreseeable non-clinical emergency situation, including issues with premises or loss of staff.

Equipment

There was sufficient equipment on site, such as equipment used for emergency situations, and a wheelchair for the

Are services safe?

safe transfer of less mobile patients from car to surgery. However we were told that there were no recorded checks to demonstrate that these were maintained and safe to use.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

We found that the practice positively engaged and worked in partnership with other services to meet the needs of patients in a co-ordinated and timely way. All staff we spoke with told us that they felt supported. Training was in place to ensure patients were treated by skilled staff.

The practice had health promotion and prevention systems in place, and was effective at monitoring, managing and improving outcomes for patients.

Our findings

Promoting best practice

We found that clinical meetings were held every month and involved all clinical staff on duty. As part of these meetings clinical audits were presented and discussed. Clinical audit is a process to improve patient care and outcomes through the systematic review of care and implementation and review of change. Significant events analysis and updates on best practice were also discussed at the clinical meetings. Every two to three months speakers were sourced externally, for example, a hospital oncologist. This promoted both best practice and links with other health professionals.

We spoke with three GPs at the surgery who all demonstrated a sound knowledge of evidence based care and management using best practice examples, for example, tighter control of cholesterol levels for patients with diabetes.

We found that all clinical staff we spoke with had a robust understanding of consent, the Mental Capacity Act (MCA) 2005, the Gillick competency and Fraser guidelines. The purpose of the Mental Capacity Act 2005 (MCA) is to empower people to make decisions wherever possible and to protect those who lack capacity by providing a flexible framework that places individuals at the heart of the decision making process. The Gillick competency and Fraser guidelines relate originally to a legal case around whether doctors can give contraceptive advice or treatment to under 16 year olds, but now look at whether a child has the competency to make decisions and understand the implications of that decision.

Management, monitoring and improving outcomes for people

We found that where clinical audits were completed, these were then re-audited at appropriate intervals. One of the GP partners was able to give us examples of where their auditing had changed their practice and improved outcomes for patients.

We found that the practice was aware of its performance within its Clinical Commissioning Group area (CCG) and worked to improve this. The surgery was currently in the upper quartile for Quality and Outcomes framework data (QOF). QOF is a voluntary incentive scheme for GPs in England.

Are services effective?

(for example, treatment is effective)

At the time of our inspection we found that the practice was currently involved in completing health reviews for all over 75 year olds, those with long term conditions and those on end of life care. After these reviews a care plan of support needs had been written. All over 75 year olds also had a named GP, this included registered patients who did not take medicines and did not have an ongoing medical condition. This work was part of a national initiative, although no parameters had been given for the health review work and therefore the practice was proactive in choosing its most vulnerable groups.

Staffing

Staff told us that they felt well supported. They told us if they needed any changes to working practice they felt able to discuss this with the practice manager and GP partners. One member of nursing staff told us that if their list of patients was large or they were running late, other nursing staff would help out in assessing patients on their list.

Staff had a robust induction which included shadowing, where appropriate. We spoke with one member of staff who told us that they had a good induction. Another member of staff told us that when they were first employed by the practice they were given longer appointment times to give them the extra time potentially needed as a new employee. These strategies showed that the practice considered how best to support new staff.

There was an induction pack for new GPs. We saw that where new GPs had a particularly complex consultation there was the ability for two GPs to be present, in order to provide support.

We saw that the locum GP was based in a consulting room close to the majority of the GP partners. The locum GP told us that that GP partners would see them after surgery hours to check if they had any queries or concerns. This made them feel supported.

One GP partner told us that all staff received annual appraisals, and the GPs go through the revalidation process. GP revalidation is a process completed on a five year cycle, where doctors must demonstrate that they are up-to-date with their knowledge and skills, and fit to practice.

We found that there was a range of meetings available to different groups of staff which would provide support; minutes were kept of these meetings on the practice's intranet for staff to refer to.

We saw that where complaints raised by patients related to staff that this feedback was incorporated into their learning needs and appropriate action taken and support given.

Working with other services

We found that all GPs were aware of the multidisciplinary organisations available to give the best care to their patients. We found that the practice actively engaged and worked in partnership with other professionals and agencies to meet the needs of patients.

We were told by the GPs that regular palliative care meetings were held. We saw the minutes of these bi-monthly meetings. We found that all GPs on duty attended the meeting with other healthcare professionals, such as, a Macmillan Cancer nurse and the regional palliative care coordinator. This would ensure both co-ordinated care for those patients requiring palliative care input and enabled all GPs to be aware of these patients to provide the best care.

We found that information provided by out of hours services was reviewed by the first GP to arrive at the practice the following morning, and then any action required allocated to the appropriate member of staff.

We found that where referrals were made to other professionals the content of those referrals contained the relevant detail. We saw that there was a system in place to follow up referrals.

Health, promotion and prevention

We spoke with one of the GP partners who told us that new adult patients were offered an appointment with a Health Care Assistant (HCA) and then referred through to the GP if there were medication needs. At the time of our inspection, children were not offered a new patient check, but the practice was considering whether this needed to change. During appointments the HCA assessed risk factors for developing long term conditions, for example, smoking, body mass index, blood pressure and family history. The GP partner told us that all women with a history of gestational diabetes were being offered annual fasting glucose checks which would be done without the need to see a doctor.

We spoke with one of the practice nurses about flu vaccinations and uptake by patients. They told us that the practice had run a Saturday flu vaccination programme throughout last October. They also gave flu vaccinations during regular appointment times to avoid patients needing to re-attend.

Are services effective?

(for example, treatment is effective)

We found that there were displays in the waiting room that provided information about healthy eating and different medical conditions.

We were told by one of the GP partners that several of the practice's GPs had attended a Health Coaching Course provided by NHS England which showed doctors how to support patients to make their own decisions and make healthier lifestyle choices. The GP told us that their own practice had changed as a result of this course.

We spoke with nursing staff who confirmed that smoking cessation was available and patients would be referred for this if they wished to be, especially pregnant women and those with asthma.

We spoke with one of the patients to check if cervical screening appointments were at convenient times for working patients. They told us that they did not have a problem arranging a convenient appointment.

We asked the nursing staff about their childhood vaccination programme. They told us that all nursing staff gave childhood vaccinations. There was a robust system in place for following up those children who had not attended for their vaccination.

Are services caring?

Summary of findings

The service was caring.

People told us that generally staff treated them with respect and dignity. Consent was obtained and care and treatment discussed with patients in order for them to make an informed decision.

We saw examples during our inspection of patients being treated with respect, dignity compassion and empathy by staff.

Our findings

Respect, dignity, compassion and empathy

Our review of the comment cards left by patients for us showed that people felt they were treated with dignity and respect. One comment card stated that the staff at the practice were professional and caring. They said doctors were attentive and listened carefully to the problem before deciding a course of treatment. Another reflected that doctors gave the patient time to talk during consultations, and that when issues arose they were dealt with effectively.

Generally other people we spoke with during the inspection were positive about the attitude of the staff and how they were treated.

During our inspection we saw examples of how staff responded to patients and their relatives in a manner that showed compassion and empathy. We spoke with staff and asked them questions relating to how they interacted with patients. We were given working examples by GPs of this. Staff responses confirmed that patients were treated with dignity and respect.

The arrangement of reception staff meant that there were staff based upstairs to deal with calls where private and confidential information needed to be exchanged. We saw that there was a room available by reception for patients to discuss confidential concerns. We saw signs informing patients that chaperones were available during consultations of an intimate nature. The practice's training record showed that staff were trained for this role.

We found that the practice held a list of recently deceased and seriously unwell patients in an area accessible only to staff. This enabled all staff to be able to respond appropriately if a relative contacted the practice. The practice would also share this information, with consent and as appropriate, with other relevant agencies. When a person's relative had recently deceased the practice would contact the family to offer condolences. The practice kept a list of carers and offered support from a social care advisor on benefits and funeral planning.

We found that the practice had used available funds to provide a counselling service to patients. Referred patients could be seen within one week of referral or in certain circumstances the same day.

Are services caring?

Involvement in decisions and consent

Most people we spoke with told us that they felt involved in decisions relating to their care and treatment. They told us that treatment options were explained so that they could make an informed choice. They also told us that they were asked for their consent before receiving treatment.

Staff at the three care homes we spoke with confirmed that staff from the practice sought consent from patients before providing treatment. Where a decision concerning treatment needed to be made in the patient's best interest this was done appropriately.

Clinical staff we spoke with had a good understanding of consent and how to apply it. Clinical staff were able to give us examples of where they had used the Gillick competency assessment, and also where they had acted in the best interests of patients without the capacity to consent. Clinical staff spoken with were able to tell us the appropriate documentation that needed completing for these patients. The Gillick competency and Fraser guidelines relate originally to a legal case around whether doctors can give contraceptive advice or treatment to under 16 year olds, but now look at whether a child has the competency to make decisions and understand the implications of that decision.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs.

We found that the practice understood of the demographic of its population and adjusted its resources to ensure patients' needs were met.

We found that there was timely access to clinical staff both for routine and urgent appointments. Where patients chose to attend A & E or walk-in services, it was not due to a lack of appointments at the GP practice.

There was an effective complaints system in place, with follow up actions evident, where appropriate.

Our findings

Responding to and meeting people's needs

The practice offered self-bookable screening for Abdominal Aortic Aneurism (a weakening and expansion of the aorta, the main blood vessel in the body). This screening could also be accessed by patients registered at other practices. This facility empowered patients to take some responsibility for their own health and wellbeing, and ensured that patients from other practices could do so too.

Through conversations with one of the GP partners we found that the practice was aware of its population demographic and how changes to other services around it and potential new housing would affect this demographic in the future. We found the practice was taking proactive steps to protect the services currently provided for patients and to build connections and services to cater for the change in demographic. The practice staff told us that they were actively recruiting new staff in order to ensure that any large increase in registered patients did not affect their existing practice population.

The area that the practice was based in had several small care homes for people with learning disabilities. The practice ensured that clinical staff visiting these homes were consistent to avoid the distress that can be associated with new faces.

One of the GP partners told us that GPs tried to build up a relationship with their patients in order to best understand their needs. We found that the appointments system had a built in flag for reception staff so that where a patient required a longer appointment this was automatically given.

Access to the service

Prior to inspecting the practice we sought feedback from other agencies. We found that despite positive feedback on the service there were high numbers of patients using accident and emergency (A&E) at the local hospital during practice opening hours. We discussed this with the practice in terms of access to appointments. We viewed data compiled by the practice on time taken to answer calls and found the majority of calls were answered within two minutes. The data showed most calls in the queuing system were answered within 20 minutes at peak times. We looked at the online booking system and found that there were still bookable urgent appointments for the day of our

Are services responsive to people's needs?

(for example, to feedback?)

inspection. We also found on the system that we could book a routine appointment with the lead partner a week in advance. Staff told us that they thought patients may be attending A&E or the walk in centre through choice and not necessarily lack of appointments as both are so close to the practice. The practice manager planned to work with other agencies to try and establish whether those attending A&E and the walk in centre were doing so appropriately and if not, establish why they were not using Mill Road Surgery.

The majority of patients that we spoke with confirmed that, although at times they had to wait in a telephone queue to make an urgent appointment, they were usually able to. Generally people were happy with continuity of care although three patients we spoke with told us that they found it difficult to make an appointment with their preferred GP and may have to wait up to three weeks.

The practice had extended hours on two evenings a week and had put a bid into the Clinical Commissioning Group (CCG) to offer an early morning session once a week. The practice took part in pilots to offer a Saturday and Bank Holiday service which the practice manager told us was well received by patients, however there were no plans for this to be permanent. This showed that the practice was exploring different options to ensure that access to services was convenient to the whole of the surgery's patient population.

Concerns and complaints

We viewed the practice's complaints procedure and the practice manager talked us through the stages of the process once a complaint had been made. We found that there was a system in place for handling complaints. We saw that although there was no poster in the waiting area displaying who to contact with complaints, concerns or comments, several of the leaflets about the practice available in the waiting area made reference to the complaints policy and who to contact.

We spoke with patients and staff from three care homes about their experience of making a complaint or raising concerns. The majority had not had any issues but where concerns were raised they were satisfied with the resolution. One comment card we received reflected that they found staff were polite and helpful, and queries were dealt with straight away.

We saw an anonymised summary of all complaints made during the last year and found appropriate action had been taken to investigate the complaints. Where learning or changes to practice could take place this had happened. The practice was responsive when dealing with complaints and/or comments.

We found via several different sources of information that a source of patient dissatisfaction was the practice's 0844 number. We spoke with the practice regarding this and were told that the service was originally set up in response to patients frustration at getting an engaged tone and that at the time this was the only option. The practice was fully aware of the issue and had looked into the possibility of changing the telephone system however due to contractual obligations this would not be cost effective and would have a detrimental effect on the practice's ability to provide other services. The practice was committed to changing the number as soon as they were able to without a negative effect on the practice.

Are services well-led?

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

Summary of findings

The service was well-led.

Governance arrangements at the practice were clear and leadership was strong. The culture of the practice was open and staff told us they felt empowered to report any concerns or to make suggestions for improvement. Staff were encouraged to take ownership of their responsibilities. There was a strong focus on improving quality of care through learning. This was evident across all staff groups within the practice.

The practice was supportive of staff development and patients' views. Both staff and members of the patient participation group (PPG) told us that they felt supported and listened to. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. Staff were aware of the key risks to the organisation and had undertaken planning in order to address these risks.

Our findings

Leadership and culture

Leadership roles for the management of the practice were shared between the GP partners and other staff. There were named leads of areas such as safeguarding, dispensing and complaints. This ensured that staff were clear of their accountabilities and knew who they should go to for support.

Our discussions with clinical and non-clinical staff across the practice revealed that the practice culture was open and honest. All staff we spoke with described an open and supportive culture where errors could be reported, discussed and learned from. We saw several examples of how this had worked in practice and noted that staff groups demonstrated real learning from this process. The GP partners met informally every morning. It was clear that the GP partners worked closely together and supported each other.

One of the GP partners told us that the aim of the practice was to support patients to seek advice and treatment in a secure, safe and clean environment. They felt that confidentiality and safeguarding were key principles. Staff were encouraged to take ownership for their actions and responsibilities.

Governance arrangements

Governance arrangements at the practice were clear. Staff knew what they were accountable for, both as individuals and as teams. Most of the policies and procedures for the practice supported this. We saw meeting minutes which demonstrated that learning from complaints, incidents and significant events were discussed at staff meetings. We also discussed incidents and complaints with staff who demonstrated that they had improved their service as a result of the investigation process.

The practice had systems in place in the event that the practice manager was unavailable in an emergency.

We saw there were systems in place relating to information governance. Access to clinical notes was restricted to those who needed it. Telephone calls requiring privacy were conducted in an office away from patients. Staff had received training in information governance. All staff told us that the practice regarded patient confidentiality very highly.

Are services well-led?

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

We tested and found that the codes used within the system to identify certain types of patients, for example, those who had had a cervical smear, were accurate. This gave us some reassurance that data quality standards were high.

Systems to monitor and improve quality and improvement

The practice had an on-going audit cycle to mitigate risks and to facilitate on-going improvement and learning. For example, a GP partner told us that they conducted warfarin audits on an on-going basis. Following two incidents where patients experienced issues around their INR level (a blood clotting test used when patients are on warfarin medicine), a discussion took place at the practice's clinical meeting and a new system was designed to improve outcomes for patients with an unstable INR.

The practice had arranged for a pharmacy technician to attend weekly to ensure that new guidelines were being addressed. The technician also conducted medicine audits, for example, they recently audited osteoporosis medicines, taking into account recommendations from a local rheumatologist, which led to positive outcomes for patients.

Patient experience and involvement

We spoke with several members of the patient participation group (PPG) by email prior to the inspection and on the day. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. They told us that the practice was actively involved in their meetings, listened to feedback and where possible actioned this. They told us that any PPG activity was supported by the practice. We requested the members of the PPG share with us what population group they felt they belonged to. We found that the majority of population groups were represented. During our inspection the PPG was at the practice raising awareness of the group. The outcome of this activity would possibly give a voice to those population groups not represented in the PPG at that time.

Following a trial of Saturday and Bank Holiday appointments a patient survey was completed to gauge feedback on the service. People found the service easy to access. When asked what they would do if they were unable to get an appointment on this day the majority of people said they would wait until the following week to get an appointment. A small percentage said they would have gone to the walk in centre.

Staff engagement and involvement

All staff we spoke with told us that they were actively encouraged to report concerns. Other staff told us that they felt able to approach senior staff where they felt changes to practice were needed and that they would be listened to.

Staff confirmed that the culture of the practice was very open and that this encouraged staff engagement.

Learning and improvement

We found that there was a strong focus in the practice on learning from events and using clinical audits in both the pharmacy and the surgery to drive improvements. Clinical staff we spoke with were able to give us examples of this. Learning was shared throughout the practice.

We saw that where an incident occurred involving a 'lost' call from reception to clinical staff, that procedures were reviewed and updated. We spoke with reception staff regarding this and found that they were all aware of the new process.

Identification and management of risk

The practice worked proactively to respond to the increasing population in the area by identifying and mitigated any risks before they became an issue. An example of this is the practice has been in discussion with the local authority around the proposed infrastructure of a planned new build site nearby and how the practice could fit in with this infrastructure.

One of the GP partners told us that they monitored individual staff performance around coil fittings, implants and minor surgery e.g. basal cell carcinoma removal (records were checked and they ensured that histology results were known). This ensured that any issues were identified in a timely manner.

Older people

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

Summary of findings

The practice was proactive in establishing links with other health and social care professionals so that when patients required it there was access to good co-ordinated care.

Our findings

We found that the practice was registering more older people than they had previously had on their register due to other local GPs retiring. The practice was working to build links with district nurses so that when their patients needed a district nurse there was an established working relationship in place.

The practice held weekend flu vaccination clinics and also tried to offer them when patients attended for other issues to avoid patients having to re-attend.

Staff told us that the practice had access to a social care advisor who could advise patients on benefits and funeral planning.

People with long term conditions

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

Summary of findings

The practice had systems in place to monitor those with long term conditions and offer reviews as appropriate.

Our findings

The practice audited patients with diabetes monthly. If the patient had not attended for their six month review, the practice would contact the patient to arrange this.

On-going clinical audits were used to improve outcomes for patients with a long term condition. For example, following a cholesterol audit for patients with diabetes new protocols were drawn up.

Patients with a history of stroke or transient ischaemic attack (TIA) were called into the practice for review as well as being given repeat prescriptions, in order to monitor them.

The practice was committed to reviewing all patients with long-term conditions and putting a care/support plan in place for them.

Mothers, babies, children and young people

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

Summary of findings

The practice had systems in place to offer co-ordinated care to mothers, babies, children and young people. Clinical staff were aware of consent and capacity principles and how to apply these.

Emergency medicines for children, for use in the event of a severe allergic reaction, were out of date.

Our findings

The practice was aware that a large proportion of its patient population were mothers, babies, children and young people.

The clinical staff we spoke with had a thorough awareness of principles of consent for under 16 year olds.

The practice had links with both midwives and health visitors and shared access to records. The midwife held a clinic two days a week at the surgery and if required could consult with the doctors whilst the patient was still on-site.

The practice had a system in place for monitoring uptake of childhood vaccination.

The practice did not have a defibrillator suitable for use with children. Children experiencing a cardiac arrest would be taken straight to accident and emergency at the local hospital.

Children could not be guaranteed that the medicine provided in the event of a severe allergic reaction, in an emergency, would be successful, as we found that this was out of date.

Working age people (and those recently retired)

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

Summary of findings

The practice had reviewed it's access hours to ensure the service was accessible to those patients of working age.

Our findings

We found that the practice took part in pilots around alternative access times. They offered evening sessions in order to accommodate commuters and to fit around working hours. The practice had put in a bid to its Clinical Commissioning Group to offer extended hours one morning a week as well.

One person we spoke with told us that they were able to access smear tests at convenient times.

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

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

Summary of findings

Staff understood the needs of patients with learning disabilities and tried to support them in ways that would cause them the least distress.

The practice had a system in place to ensure that patients were reviewed annually.

Although the practice did not have any homeless people registered with them a policy was in place to support access.

Our findings

The practice had arrangements to offer services to several care homes nearby that supported people with learning disabilities. We found that staff completed home visits as necessary. The practice had arranged for these patients to see a consistent GP to minimise any distress an unfamiliar face may have.

If a patient with a diagnosis of learning disability did not attend their appointment and had not cancelled in advance then staff would go to them.

The practice offered blood tests, unless to do so would cause the patient undue distress. All patients with learning disabilities were offered an annual check-up.

Clinical staff told us that they would always try to obtain consent from the patient and staff at two nearby care homes confirmed this. Where a person could not consent staff would act in accordance with the Mental Capacity Act (MCA).

The practice manager informed us that although a policy was in place the practice did not, at the time of our inspection have any patients registered that were homeless.

People experiencing poor mental health

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

Summary of findings

The practice had systems in place to offer support to people experiencing poor mental health. Staff were trained to deal sensitively with patients presenting in crisis either on the telephone or in person.

Our findings

We found that the practice had a system for identifying patients with mental health needs so that when they contacted the practice for an appointment they would be seen by the clinical staff best placed to deal with their problem. If a longer consultation session was required this would also be given.

The practice had access to counselling onsite within the week. Staff throughout the practice were trained to deal with patients ringing up in crisis, meaning that patients had access to appropriate care as they needed it.