Roseheath Surgery Ltd

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	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Roseheath Surgery Ltd. ("the practice"). Our inspection was a planned comprehensive inspection which took place on 12 February 2015.

Roseheath Surgery Ltd is rated overall as good. We found care and treatment delivered to patients was safe, responsive and caring. Leadership was present and staff felt supported in delivery of their duties. We found some improvements were required in the domain of effective.

Our key findings were as follows:

- The practice provided safe care and treatment to patients. Multiple data sources were used by the practice to drive improvements. Staff understood how incidents should be reported, although there were gaps in staff knowledge of what should be reported, for example, in response to any patient complaint about a clinician.
- Some staff had not received annual performance appraisal and key training updates
- Patients commented positively about the care and treatment they received, and on how they were treated with dignity and respect.
- Patients we spoke with told us the practice was responsive to their needs; appointment availability was good and patients said that they did not experience lengthy delays when trying to book appointments for example, for the following day.
- All staff we spoke with told us they received good support from the office manager. The lead nurse told us they had a good working relationship with the lead GP for the practice, and that GPs and nursing staff worked well together.

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

Importantly, the provider must:

- Ensure that staff performance review and appraisals are in place and delivered annually and that training meets the needs of all staff.

Summary of findings

In addition the provider should:

- Keep sufficient records at the practice to enable review of performance year on year, for example, in relation to complaints. Also, keep copies of records to show legionella checks have been completed.
- Complete audit cycles to enable conclusions to be drawn and improve patient outcomes.
- Check that the correct data search is applied to identify those patients vulnerable to unplanned hospital admission, and that their care plans are reviewed by those ultimately responsible for their care.

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?

Good

The practice is rated as good for providing safe services. We saw that the practice had carried out a number of audits on patient treatments, patient referrals to secondary care, and transfer of patients back to GP care. Although these were not completed audit cycles, it demonstrated checks were made on the handling of correspondence by practice staff, records of changes to medications, and any follow up work required of the GP treating those patients. From this we could see that staff followed set protocols at practice level, which reflected best practice guidance. Incident reporting and analysis was in place at the practice and staff felt confident about raising any concerns with the lead GP.

Are services effective?

Requires improvement

The practice is rated as requiring improvement for providing effective services. We were shown several audits conducted by the practice, but these were not fully completed audit cycles. Although conclusions could be drawn from initial findings, these could not be tested as the audit cycle was not repeated. The practice had produced care plans for those patients who were vulnerable to unplanned hospital admission. However, on checking a sample of care plans, we found these patients had attended a local accident and emergency unit, and did not fit the criteria of this national initiative, of being at risk of unplanned hospital admissions. We also found the care plans, where appropriate, where lacking in detail. The practice did not have an effective system in place for the appraisal of staff, review of their performance or identification of learning needs. We saw that several staff members had not had annual appraisals for some time. Learning needs such as training on the Mental Capacity Act 2005 and training on issues around consent had not been addressed. The practice did not record complaints received about any clinician appropriately and review these at staff appraisals.

Are services caring?

Good

The practice is rated as good for providing caring services. All patients we spoke with on the day of our inspection, commented that staff treated them with dignity and respect. Patients views expressed in the 15 CQC comment cards we received, mirrored those of the practice patient survey of January – March 2014, where patients said overall that they were happy with the services provided by GPs and nurses at the practice.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. Feedback from patients was acted on by the practice. Availability of on-line appointments was good, and step by step instructions on how to register to access on-line appointments had been drawn up and issued by the practice. Practice staff monitored the availability of GP appointments to spot any rise in demand and react where possible to do so.

Are services well-led?

Good 

The practice is rated as good for providing a well-led service. We saw that the lead GP spent time at the practice. Although staff had commented that this could be limited, they acknowledged that time pressures meant the lead GP could not always attend practice meetings, or spend a day each week at the practice. The office manager provided good visible leadership to support staff. The GP's who worked regularly at the practice supported each other and the practice nurses. We saw that longer term working relationships, between the clinicians and staff had helped the practice team stabilize during periods of change in how primary medical services were delivered.

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

Requires improvement

The practice is rated as requires improvement for the care and treatment of older people. We made checks to see if the practice had identified all patients over the age of 75 years who were vulnerable to unplanned hospital admission. These patients would require a care plan which gave details of their named GP and contact number, and details of care and treatment that would reduce the possibility of unplanned admission to hospital. When we reviewed a sample of these care plans, we found the data manager had identified patients on the basis of attendance at the local accident and emergency unit, rather than the specified criteria of the national initiative. Further, this had not been picked up by the GP who signed off care plans for those patients. Care plans we reviewed were insufficiently detailed and therefore not fit for purpose.

The practice had performed well in other areas such as delivery of flu vaccinations to older patients who may be more vulnerable to infection, and in screening of patients for early signs of memory loss that may indicate dementia.

People with long term conditions

Good

The practice is rated as good for the treatment of patients with long term conditions. The practice nurse prescriber treated patients with long term conditions, which allowed continuity of care for patients. The percentage of patients at the practice with a long-standing health condition was 65%, compared to the England average of 53%. The nurse told us they would do home visits to patients if this was required, to ensure patients received the care and treatment they needed.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care and treatment of families, children and younger people. The practice had a higher rate of younger patients, than the England average for a practice of a similar practice. For example, the percentage of patients under the age of 18 registered with the practice was 23.6%, compared to the England average of 20.9%.Despite the teenage conception rate in Knowsley being slightly lower than the North West average (45.8), rates remain higher than the national rate for under 18 conceptions at 43.5 per 1000 in 2008 compared to 39.8 per 1000 nationally. We found the practice had no particular initiative in place to engage with this patient group with a view to addressing this statistic. The practice told us they referred younger patients to a

local organisation for contraceptive and sexual health advice, but there was no system in place to follow-up those referrals. There was some basic information on the practice website about contraception clinics and information regarding prescribing contraceptives to patients under the age of 16. The practice nurse we spoke with had not received training on the Mental Capacity Act 2005, The Childrens' Acts 1989 and 2004, or Gillick competency. The practice had performed well in vaccination and immunisation of children, and offered same day appointments to any patients who needed to see a GP urgently.

Working age people (including those recently retired and students)

Good

We saw that the practice had systems in place to quickly identify and target those patients who should be offered a seasonal flu vaccination. However, take-up rates were reported as being low for pregnant women and those eligible patients under 65 years of age. The practice was working to address this, for example, by asking each patient on arrival at the practice, to confirm all their contact details were still correct. Updates on the practice performance in this area were communicated to staff at each weekly and monthly practice meetings. The needs of working age patients were considered in how the practice gave access to appointments. For example, by offering appointment booking and repeat prescription requests on-line. The practice responded quickly to any confirmed cases of meningitis reported in Liverpool, and contacted those patients who may require a meningitis C vaccine, particularly patients in the student population group who were registered with the practice.

People whose circumstances may make them vulnerable

Good

The practice offered annual health checks to patients with a learning disability, and regularly ran searches to identify any other patients that may be vulnerable, for example, patients who had experienced domestic violence. These patients were offered longer appointments to ensure they were given sufficient time to discuss their health care needs. The practice staff were aware of patients who were carers and we saw that they were supportive of these patients. For example, staff recognised that patients with caring responsibilities may not be able to attend the practice at certain times of the day, so offered appointment times wherever possible, that accommodated this.

People experiencing poor mental health (including people with dementia)

Good

The practice used a risk stratification and case finding tool to identify high risk patients who may benefit from dementia screening

and referral to memory clinics. The practice worked with local mental health teams and referred those patients requiring services to locally run clinics in the area, led by a mental health specialist. Waiting times for these services were no longer than two weeks. We saw from minutes of practice meetings that staff continually ran searches on the patient database to ensure patients who fell within this population group had not been overlooked.

Summary of findings

What people who use the service say

On the day of our inspection we collected 15 CQC comment cards, where patients had expressed their views about the service. All comments were positive. Patients commented that they received a good service from doctors and nurses at the surgery. Some patients commented on the information clinicians gave them about their treatment and how it helped them make informed decisions and to take ownership of their healthcare.

We spoke to four patients who were visiting the practice on the day of our inspection. Two patients told us they preferred seeing the senior nurse practitioner to seeing a GP. When we asked why this was, both told us they valued the continuity of care they received from this nurse. One patient told us there had been changes to the doctors who were regularly available at the surgery, and they felt this had affected continuity of care.

A patient survey was carried out by the practice between 31 January 2014 and 14 March 2014. A number of questionnaires were handed out to patients visiting the practice during this period. Additional copies were available at reception and in patient waiting areas. A box for posting replies was available in the reception area. Eighty six responses were received. The executive summary did not say how many questionnaires were handed out which would give a more accurate indicator of response rate. Of the respondents, 98% of patients said they were happy with the opening hours of the surgery. 98% of patients said they were happy with the service provided by reception staff at the surgery. 90.7% of patients indicated they were satisfied that the doctor listened to them in consultations. 93% of patients felt the GP was good at treating them with care and concern. Areas that patients indicated as requiring improvement included waiting times when a patient had arrived for their appointment, and access to on-line appointments. The surgery had responded proactively by providing access to on-line appointment booking and also producing a short step by step guide for patients to follow, when registering for on-line access and for booking an appointment.

Areas for improvement

Action the service MUST take to improve

Ensure that staff performance review and appraisals are in place and delivered annually and that training that meets the needs of all staff.

Action the service SHOULD take to improve

Keep sufficient records at the practice to enable review of performance year on year, for example, in relation to complaints. Also, keep copies of records to show legionella checks have been completed.

Complete audit cycles to enable conclusions to be drawn and improve patient outcomes.

Check that the correct data search is applied to identify those patients vulnerable to unplanned hospital admission, and that their care plans are reviewed by those ultimately responsible for their care.

Roseheath Surgery Ltd

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP and a practice manager specialist advisor.

Background to Roseheath Surgery Ltd

Roseheath Surgery is located within a purpose built facility, sharing the building with two other GP practices and a number of other community health services. The facility is part of a complex that offers a library, post office and citizen's advice bureau. The facility is served by a regular bus service.

The building meets the requirements of the Equality Act 2010, having good access for wheelchair users and other patients with impaired mobility. Parking for disabled patients is located close to the entrance to the building, and access doors are automated. Roseheath Surgery is well signposted within the building, and is based on the ground floor. The patient waiting area on the ground floor is used by patients of the three practices within the building. Toilet facilities which are accessible to disabled patients are available on the ground floor. The bathroom has baby changing facilities and a private room for any breast feeding mothers is available on the first floor.

The practice is open from 8.00am to 6.00pm each evening, except on Mondays when extended hours are offered until 7.30pm. The practice register is open to new patients; at the time of our inspection the number of patients registered with the practice was 2,284.

Four GPs work at Roseheath Surgery; the clinical sessions delivered allow for 96 GP appointments each week. The practice can also deliver up to four home visits each day except for Thursday when no GPs are practising at Roseheath Surgery. The practice has two nurses, one of whom is an advanced nurse clinician who can prescribe across the British National Formulary. (BNF). Both nurses can make home visits if a patient's treatment requires this. A number of clinics are delivered by the nurses, for example, in chronic disease management.

The practice delivers services under a Primary Medical Services (PMS) contract.

The practice serves patients who live in an area rated as being in the second most deprived decile. Data we reviewed before our inspection showed that in 2011, alcohol attributable mortality in Knowsley was lower than the North West as a whole (although not significantly so). However deaths related to alcohol were on the increase. Knowsley had significantly higher rates of hospital admissions in 2011 for alcohol related harm than the North West and England.

Despite the teenage conception rate in Knowsley being slightly lower than the North West average (45.8), rates remain higher than the national rate for under 18 conceptions at 43.5 per 1000 in 2008 compared to 39.8 per 1000 nationally. Parts of North Kirkby in 2011 had conception rates of above 60 per 1000 under 18 year old young women. Although the number of conceptions has fallen by 21% since 1998, over 50% of these conceptions ended in abortion, suggesting that these

were unplanned pregnancies.

There are no branch surgeries linked to Roseheath Surgery. At the time of our inspection, out of hours services were provided by another external provider. Urgent Care 24 (UC24).

Detailed findings

Why we carried out this inspection

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

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. The practice sent us a range of information for review before our inspection, such as current policies and procedures and recent clinical audits conducted. We carried out an announced visit on 12 February 2015. During our visit we spoke with a range of staff including the lead GP, the data and performance manager, the business manager, office manager, advanced nurse practitioner and other administrative support staff. We were able to speak to four patients on the day of our inspection, and met with a member of the Patient Participation group (PPG). We reviewed 15 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice is rated as good for providing safe care and treatment. The practice had a range of policies and procedures in place to support safe working of staff and to protect visitors to the practice from avoidable harm, such as health and safety policies and incident and accident recording policies. Staff were encouraged to report any safety incidents and these were discussed at weekly practice meetings. Minutes kept of these meetings confirmed this information.

The office manager was knowledgeable on what should be reported, to whom and what follow-up action was required to ensure learning came from any safety related incidents. The manager could demonstrate that they had access to on-line materials which could be used for guidance and training on this. Information from NHS England showed that the practice had a good track record in respect of patient safety.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. We were able to review three recent examples of significant events, which had been logged, recorded and reviewed by clinicians and staff. As records were only available for 2014-15, we were unable to review previous incidents to see if learning from them had been applied in practice. Significant event analysis was a standing item on the weekly practice meeting agenda. We could see from minutes of meetings that staff were encouraged to discuss any incidents in an open manner, which encouraged learning and a 'no blame' culture.

Reliable safety systems and processes including safeguarding

The practice had a policy for child and adult safeguarding. Staff demonstrated knowledge and understanding of safeguarding. They described what constituted abuse and what they would do if they had concerns. Staff had undertaken electronic learning regarding safeguarding of children and adults as part of their essential (mandatory) training modules. GPs had undergone safeguarding training to the appropriate level and the date this was due to be refreshed was recorded within a centrally held staff training record. The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children. Staff we spoke with said they were comfortable about raising concerns, and told us who they would report concerns to when the safeguarding lead GP was absent.

There was a system to highlight vulnerable patients on the practice's electronic records system. This included information so staff were aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. The practice also had systems in place to highlight the records of patients who were subject to domestic violence. We saw how this had helped staff deal safely with a significant event, which indicated systems in place worked well.

The practice had a chaperone policy in place and this was advertised to patients in reception and waiting areas. We were told that nurses would be approached to offer this service in the first instance. If a nurse was not available, administrative support staff would act as a chaperone. We found these staff had received training on how to act as a chaperone, and had undergone enhanced disclosure and barring checks to check their suitability for this role.

Medicines management

The practice had systems in place to safely handle, prescribe and administer medicines. Systems in place ensured a medicines review was recorded in all patients' notes for patients being prescribed four or more repeat medicines. We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank/local holidays). The practice met on a regular basis with the local area teams' medicines manager and CCG pharmacists to review prescribing trends and medication audits.

Practice staff showed us how they ordered, stored and maintained sufficient stocks of medicines, for example, vaccinations and immunisations. These were kept in a dedicated fridge which was temperature controlled. Records were kept of checks made to ensure the fridge stayed within safe temperature limits. Stock within the fridge was rotated correctly to ensure that medicines would be used in 'best before' date order. We did find that there was a lot of stock kept in the fridge, which suggested that

ordering of stock was not as well managed as it could be. Also, this meant that some medicines in similar packaging, was stored on the same shelf, which could increase the risk of error.

The practice staff were able to demonstrate that contingency plans in place to deal with medicine emergencies were effective. We saw from a significant event that the fridge, when checked by staff, was thought to be faulty. Arrangements in place to use a fridge belonging to another practice within the building were utilized. This demonstrated that the regular checks of staff on fridge temperatures and contingency arrangements worked in practice. The practice had systems in place to ensure that stocks of prescription pads were kept securely. When placed in printers, these printers were in secure areas. Reconciliation of prescription pads and regular audit checks ensured all prescriptions could be accounted for.

Cleanliness and infection control

The practice had an infection control policy in place. Cleaning of the practice was managed and monitored by the caretakers in the building. Cleaning schedules were in place for all parts of the building, treatment rooms and consulting areas. Our visual inspection showed the practice was clean, tidy and well maintained.

In treatment rooms we saw that appropriate segregation of general and clinical waste was in place. Contracts for safe removal of clinical waste and sharps bins were in place with the owners of the building. Waste bins were all foot pedal operated and all sinks in consulting and treatment rooms had lever operated taps. Clinical items, such as syringes were for single use and these were disposed of in the correct containers. All single use items were in plentiful supply in each consulting and treatment room. Adequate hand washing materials and paper towels were available for use. A cupboard for cleaning materials was stocked with products that were clearly labelled. We reviewed the infection control audit of December 2013 which showed the practice had performed well, achieving a score of 98% overall. There was no infection control audit available for 2014, or dates set to carry out this audit. We did see in minutes of the practice managers meeting of December 18th 2014, that a GP at the practice would[HJ1] be appointed as the infection control lead and that practice managers were given instructions on how to use an infection control checking tool. The infection control lead had been appointed at the time of our inspection. We were told Legionella checks were carried out by the owners of the building; the practice manager or infection control lead did not have a record of these checks for us to refer to.

Equipment

When we checked equipment at the practice, we saw this was clean, well maintained and suitable for use. Records showed that all equipment used for measurement, such as blood pressure cuffs and weighing scales had been recently tested and calibrated to ensure accuracy. All electrical appliances had been tested. The doctors and nurses consulting and treatment rooms had been checked by the practice managers on a regular basis to ensure stocks of equipment and cleaning standards were maintained.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, in the case of both nurses at the practice, records held included proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice had reviewed the skill mix of staff, including clinicians, on a regular basis and including when any clinician had left the practice, to ensure there was sufficient expertise within the practice team.

Unexpected and planned absence of staff tended to be covered by other staff within the provider group of practices. We saw, for example, how some administrative staff had worked between two practices, to offer support when needed. Recently when a GP had left the practice at short notice, another GP at the practice who worked part time delivered extra sessions to ensure sufficient GP cover at all times.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of equipment, medicines management, staffing and plans to deal with emergencies. The practice had a health and safety policy. Health and safety information was displayed

Good

Are services safe?

for staff to see. The staff handbook, issued to all staff on commencement of employment, referred to key areas of health and safety, and the responsibility of all staff to raise any concerns. The staff handbook covered the whistle blowing policy of the practice and assured staff they should always report any concerns about safety of themselves or of patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing two staff had received training in basic life support, which meant between support staff, nurses and GPs, there was sufficient cover to deal with emergencies. Emergency equipment was available including access to oxygen (belonging to another practice in the same building) and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. We checked emergency medicines and found these to be in date, suitable for use and in a location that was secure but accessible to staff qualified to use them.

The practice had a business continuity plan in place, which covered steps the practice would take to ensure services could be delivered to patients. For example, in the event of loss of IT function, power supply or in extreme weather conditions. As the practice was part of a larger group, copies of the plan were available from other sites.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We made checks to see if the practice had identified all patients over the age of 75 years who were vulnerable to unplanned hospital admission. These patients would require a care plan which gave details of their named GP and contact number, and details of care and treatment that would reduce the possibility of unplanned admission to hospital. When we reviewed a sample of these care plans, we found the data manager had identified patients on the basis of attendance at the local accident and emergency unit, rather than the specified criteria of the national initiative. Further, this had not been picked up by the GP who signed off care plans for those patients. Care plans we reviewed were insufficiently detailed and not fit for purpose.

The practice nurses delivered health checks for patients between the ages of 40 and 74 years of age. This allowed opportunistic interventions by the nurses, who could highlight resources and initiatives within the community that patients may find helpful. Patients we spoke to on the day of our inspection told us their health care needs were assessed regularly when they attended health reviews with the nurses. Patients with chronic long term conditions said the care they received from the advanced nurse practitioner was particularly good and that this nurse had a good understanding of the challenges they faced managing their conditions, for example, management of respiratory conditions during winter months.

Management, monitoring and improving outcomes for people

We asked about two areas of clinical care highlighted for improvement by statistical data, for example, unplanned teenage pregnancy and alcohol related mortality. In information supplied before our inspection, the practice stated it had "strong links with THinK, a teenage health service for young people aged 13-19 that offers advice and treatment around contraception, STI screening, pregnancy testing, smoking cessation, drugs and alcohol. The practice signpost patients where appropriate and invite the service in to practice to raise awareness with patients." When we asked the lead prescribing nurse about referrals of young people to 'Think', the nurse was unable to say how many patients had been referred to this service, or how many patients referred had attended. Similarly, when asked the practice staff were unable to say how many patients referred for advice to this service, had attended. Mechanisms in place to follow-up referral and to review whether patient needs were met, were not effective.

The practice were able to show us several data sets that they had applied some audit to, but some of these were not completed audit cycles. We reviewed one example of an audit we were given. The purpose of the audit was to measure the use of bone sparring agents in the treatment of patients susceptible to fragility fractures due to osteoporosis. The audit was not dated and did not have any identified timeframes of when results would be measured, for example, six months after implementation of the first action plan, followed by further review of the patients' health, six months after starting treatment. Another audit we reviewed involved the treatment of asthma patients and whether some patients medication could be stopped or 'stepped down'. This audit was not dated. This audit did give initial conclusions, but these were not tested and had not been reviewed. Although the audit was incomplete, information gained was useful and contributed to care planning for patients identified as being vulnerable to unplanned hospital admissions.

Two further audits we reviewed were not completed cycles,were not dated and did not have any conclusions. The lead nurse at the practice told us they were doing three clinical audits; we were shown these audits which were on antibiotic prescribing and prescribing of statins in line with the prescribing protocol of the clinical commissioning group(CCG) and best practice guidance. Both were at initial stages and were not completed cycles of audit.

The practice employed a data manager, who focussed staff on areas of Quality and Outcomes Framework (QOF) data that indicated improvements were required. This staff member was proficient in using the practice patient database to create specific patient lists, such as diabetes registers and other chronic disease patient lists. Staff had worked with the data manager to improve levels of effective read coding of patients, ensuring they appeared on the correct disease registers, which ensured their annual health screenings were completed and that medicines reviews were delivered in a timely manner.

Effective staffing

Requires improvement

Are services effective?

(for example, treatment is effective)

We found that nurses did not have access to regular one-to-one sessions or formal performance and appraisal reviews from a lead clinician or a deputy. As a result of this, no areas of development had been identified for key staff members. We found that plans for future performance appraisal of administrative staff were unclear at the time of our inspection. Learning needs of staff were not clearly identified; staff had not received training on the Mental Capacity Act 2005 covering consent issues, and other areas of training required updating. This was confirmed in a training matrix supplied by the practice before our inspection and confirmed by staff when we spoke to them on the day of our inspection.

The practice used GPs from other practices within their operational group to provide cover for planned and unplanned absences. In the past 12 months, the practice had been through a period of change, where two GPs had left the practice. It was unclear to us how the business manager and lead GP, managed succession planning to ensure that key skills remained within the clinical team that delivered services to patients at the practice. The business manager and office manager confirmed that they were able to manage and cover for planned absences of GPs, but when clinical cover at short notice was needed, this could pose problems. This was confirmed in minutes of meetings that we reviewed. The business manager told us plans were being developed to provide capacity for absence cover of clinical staff, and that this capacity would come from GPs and nurses who worked flexible, part time hours within the operational group. The practice viewed this as preferable to locum cover, wherever possible.

Working with colleagues and other services

The practice had worked with internal and external providers to secure the best outcome for particular patient groups. For example, the practice had worked with a consultant based at the local hospital, to provide clinics at the practice for review of patients with atrial fibrillation. The clinic was sponsored by a pharmaceutical company that produced medicines to treat atrial fibrillation. Patients experienced minimal waiting times for this service, and access to the consultant was in their local GP practice. The practice carried out a search of its patient register on an annual basis to identify those patients who have been diagnosed with osteoporosis, and other patients deemed to be at risk of falls. These patients could be referred to a falls assessment team who conduct a risk assessment and look to reduce the possibility of patients experiencing falls.

The practice used a referral system called Choose and Book. Clinicians could make a patient referral to secondary care whilst the patient was with them at the practice and in doing this, ensure that patient choice could be exercised.

The practice nurse told us that they regularly liaised with health visitors and community nurses, to provide effective, 'joined up' treatment of patients. However these partners did not regularly attend multi-disciplinary team meetings, to discuss patients cared for in the community.

Information sharing

We saw that effective systems were in place to share information with out of hours providers of primary care. Details of those patients added to a palliative or end of life care list, were faxed to the out of hours provider each day, who may be expected to visit them overnight.

The practice kept details on each patient record, of their carer or named person, who could be given details of when a patient's prescription would be ready for collection, or when their family member was due to see a GP for a health check or medicines review. Information shared was at a level sufficient to provide understanding that enabled safe care and treatment, but did not compromise patient confidentiality.

When we reviewed records, we saw that the practice had an efficient way of transferring a patient's information to providers of secondary care (for example, to local hospitals) to ensure patient treatment was not unnecessarily delayed. It was clear that patients referred for help with smoking cessation could be tracked but there was no follow up mechanism in place for referrals to other services, for example younger patients to providers of sexual health advice and contraception.

Consent to care and treatment

We asked administrative staff at the practice how they recorded a patients consent to treatment. Administrative staff showed us how this was recorded in a 'tick box' within the practice computer system. When we asked the lead nurse at the practice about obtaining consent, they told us this was computerised and there was no paper based consent form or record of formal assessment of capacity to

Requires improvement

Are services effective?

(for example, treatment is effective)

consent, for patients of any age. The nurse and staff we spoke with had not received training on the subject of consent, the Mental Capacity Act 2005 and issues around informed consent for patients of all ages. (The Childrens' Act 1989 and 2004 and Gillick competency).

Health promotion and prevention

All new patients who registered with the practice received a health check which helped identify those patients with long term health conditions and to schedule medicines reviews and other health checks necessary. The practice referred patients to other community services who could offer support and guidance on various health initiatives. Patients could be referred to smoking cessation clinics if they required support to give up smoking. The practice was able to identify which patients had attended this service and monitor the progress of patients. The practice was able to refer patients to services that offered talking and counselling therapies for any patient over the age of 16 years, with a view to improving mental health and wellbeing following an identified episode of mild or moderate anxiety, depression, or other social phobia. The practice also referred patients to specialist teams who helped patients recover from alcohol and drug related problems. Clinicians from these teams worked with GPs and nurses at the practice to ensure joined up support for patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice offered patients a chaperone service prior to any examination or procedure. Information about having a chaperone was displayed in the reception area. Patients we spoke with told us they were always treated with dignity and respect and that staff were caring and compassionate. We received 15 completed CQC comment cards. All cards carried positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

Patients we spoke with felt confident they had been involved in any decisions about their treatment and care.

We looked at the Quality and Outcomes Framework (QOF) information and this showed adequate results for patients reporting that the nurse of doctor was good or very good at involving patients in decisions about their care.

Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP.

Patient/carer support to cope emotionally with care and treatment

Staff told us that if a family had suffered bereavement their usual GP contacted them. This call was either followed by a patient consultation at a flexible time to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

All staff were made aware of the death of any patient registered at the practice, in weekly practice meetings. As the patient register was relatively small, this helped staff identify bereaved family members, and to afford them the compassion required when visiting the practice. Practice staff used notice boards within the reception waiting area to display details of support groups who could help patients and their carers through their treatment and management of their illness.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice commissioned a patient survey annually, which had asked questions about specific areas that patients had brought to the attention of the practice. The findings from the survey had been collated and recommendations had been drawn up. These included promoting membership of the patient participation group (PPG) to ensure it is reflective of the patient population, and that the NHS Friends and Family Test be introduced from January 2015. (Friends and Family Test is a question posed to patients who use a GP practice, asking if they would recommend their GP/practice to a friend or family member).

Tackling inequity and promoting equality

All staff we spoke with were aware of the differing needs of each population group and that access to services for all patients should be fair and equitable. Staff were able to explain what the term equality and diversity meant, but had not received training on this subject. We saw from a training matrix supplied by the business manager for the practice, that on-line training had been made available to staff and this was due to be completed within the two week period following our inspection. Three percent of the practice patient register came from ethnic minority backgrounds. In cases where patients did not speak English as a first language, staff had access to interpreter services through Language Line. A hearing loop was available at the practice for those patients with hearing difficulties.

The practice was located within a purpose built facility that met the requirements of the Equality Act 2010. Automated entrance doors to the practice had a push button opening and all corridors and entrance doors to consultation and treatment rooms were wide enough for wheelchair users.

The practice referred patients to a number of community based services that operated within the same building on certain days of the week. This enabled patients to access services that they may otherwise have to travel to a main hospital for. Patients could also 'self- refer' to some services, such as the 'Think' service for younger patients, which provided advice and treatment to younger patients on drug addiction, alcohol and sexual health.

Access to the service

Patients we spoke with told us their access to appointments was good. Appointments could be booked on-line, by phone, or in person. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice could accommodate up to four home visits a day. An advanced nurse practitioner could deliver home visits on a Thursday when no GP was present at the practice. This nurse was also able to see patients who required the services of a GP, when no GP was at the practice on Thursday of each week. The lead GP at the practice told us initially patients had complained about not being able to see a GP on a Thursday, but this had been addressed through patient education on the skills of the advanced nurse practitioner.

The practice offered extended hours on Wednesday of each week when the practice was open until 7.30pm.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. We reviewed complaints received for the year 2014-15. We were unable to compare the nature of complaints as complaint records for 2013-14 had been removed from the practice and the office manager had no way of accessing these. From complaints we reviewed, we could see that any response to patient complaints had been prompt. However, the logging of complaints was not as thorough as it should be. For example, any complaint received from a patient in relation to their care and treatment by a clinician, must be reviewed, logged and noted in annual performance and appraisal review. Also, complaints about any clinician must be notified in a return to NHS England. Although the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice had responded to the patient, learning from complaints by each clinician was limited as it was not reviewed by a peer or mentor, and any learning needs addressed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision for the future of the practice and had a strategy in place to help support this. The practice lead GP retained the services of a business manager to help develop areas of practice that supported the growth of the operational group. A QOF and data manager was also used to review data from a number of sources, to ensure patient needs were met.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in paper form and on the practice computer system. We saw that policies had been reviewed regularly to ensure they reflected any changes, for example, in relation to health and safety of staff and patients.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a named GP was the lead for safeguarding. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

Leadership, openness and transparency

The office manager and the regular, long term GP at the practice provided staff with visible leadership. Staff had commented that they thought the lead GP for the operational group should attend their team meetings and be at the practice for one day each week, to provide further leadership support. Staff however did recognise that this was not always possible due to other demands on the time of the operational lead GP. We found that staff kept in touch with the business and data managers, who visited the practice on a regular basis. Information from these two key staff members was fed down to the practice manager and other GPs working at Roseheath surgery. However, staff appeared to need more understanding of where they sat within the wider operational group and more work on leadership roles, to reflect the move from a stand alone practice, to a practice that was integrated with the larger operational group.

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

The practice used various methods to capture patient feedback and comments on how services were delivered. The practice carried out a patient survey each year, had an active patient participant group and had started asking patients to take the 'Friends and Family Test'. The Friends and Family Test is a question asked of each patient following care and treatment or other interactions with their primary care providers, asking if they would recommend the services of their practice to a family member or friend. The practice had signed up to this initiative in January 2015 and displayed results in a prominent area of the reception and waiting area.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said they were confident that their feedback would be acted upon.

The practice had a whistle blowing policy and staff were aware of and could refer to this. Staff were able to describe what they should do if they had a whistleblowing concern, and who they could go to, to report this.

Management lead through learning and improvement

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. We tracked a report on a significant event and saw how this had been reviewed with all staff at a practice meeting. Staff were encouraged to talk about how anything could have been done differently, and had been congratulated on what they had done well, for example, identifying a patient that was vulnerable and ensuring they received the support needed. Minutes of meetings were kept and available for review by staff that may have recently been on leave.

We reviewed staff training; we saw that a recently recruited member of staff had access to a programme of induction and mandatory training. We saw that there were gaps in training for established staff members, in areas such as mental capacity training including issues around consent.

Are services well-led?

Good

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

We saw that mandatory training modules, such as health and safety, fire safety, manual handling and equality and diversity were planned and were due to be delivered imminently. The practice business partner explained that due to the merging of some practices with the larger operational group, some staff had received training and some staff had missed refresher training in some areas. A fuller skills audit was planned to ensure training for each staff member was brought up to date, and diary dates booked for when training was due to be refreshed. Importantly, a system for delivery of this training was in place.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider is failing to comply with Regulation 23(1)(a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 18(2) Persons employed by the service provider in the provision of a regulated activity must- (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

This section is primarily information for the provider

Enforcement 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.