

Swanage Medical Practice

Quality Report

Station Approach

Swanage

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Swanage Medical Practice on 26 August 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned for.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about treatment.

- The practice experienced a high demand for appointments, especially during the summer months and had introduced an additional temporary residents surgery to provide care for a high number of holiday makers that attended the practice.
- Only 70.9% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group average of 78.8% and national average of 75.7%.
- 100% of people experiencing poor mental health had a care plan documented in their records within the last 12 months and the practice was proactive in supporting people experiencing poor mental health.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

The areas where the provider must make improvements are:

- The cleaning cupboard used for storing cleaning products as well as keys must be secured to prevent unauthorised access.

In addition, the provider should:

- Ensure that all staff where relevant receive updated training in key areas such as infection control and health and safety.
- Continue to monitor and improve access to patient appointments and publicise the times of extended hour's surgeries to patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed. However systems and procedures were not always followed, For example, not all staff training was up to date such as infection control. The cleaning cupboard was used for storing cleaning products. We found the door was not secure and did not prevent unauthorised access.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Patients experiencing poor mental health were very well supported with higher than average patient outcomes. However child immunisation rates for children under the age of five, were lower than the national average according to data available at the time of the inspection. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely but there was no single documented system to distribute NICE guidance to all staff. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs however some staff were overdue updates such as for Health and Safety. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect. The practice had an identified lead to support patients who were carers and provide information about the avenues of support that were available to them.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Good



Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it difficult to get an appointment with a named GP and there was a high demand for appointments, especially during the summer months. Action had been taken in response to feedback about the unavailability of appointments and urgent care appointments. These consisted of sit and wait services and telephone consultation services. The practice also provided information to patients about other places where they could obtain treatment such as minor injuries units and pharmacies. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. Some but not all learning outcomes were recorded.

Are services well-led?

The practice is rated as good for being well-led. It had a clear documented vision and strategy. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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 is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people and offered health checks for patients over the age of 75. It was responsive to the needs of older people, and offered home visits, care home visits and rapid access appointments for those who needed them. Multi-disciplinary team meetings were held to discuss the care of older patients and these were attended by community matrons, physiotherapists from the reablement team, district nurses and practice nurses.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and two nurses had completed a diploma in diabetes care. Longer appointments and home visits were available when needed. The practice also employed a nurse who specialised in cardiac care to manage and monitor the care of patients who had a history of stroke or coronary heart disease. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, named GPs and nurses worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were comparable with national averages for children under the age of two. However, data available at the time of our visit indicated that immunisation rates for children under the age of five were low in comparison to the national average. Staff followed up on children who did not attend for immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. Multi-disciplinary team meetings were held with health visitors and social services.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered evening appointments and some appointments on a Saturday morning but this service was not well advertised. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice offered a directed enhanced service to patients with learning disabilities and had carried out annual health checks for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All patients on the mental health register held by the practice had a care plan documented in their records within the last 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and supported patients to access support organisations and voluntary organisations. A counselling service was available within the practice. GPs reviewed medicines for patients experiencing poor mental health, prescribing on a weekly basis if required. The practice ran a weekly report to identify patients who had been diagnosed with depression and checked their records to see when they were next due a review.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing in line with local and national averages in most areas, with the exception of those indicators that were associated with waiting times. There were 124 responses and a response rate of 48.6%. This is 1.06 % of the practice population.

- 81.1% found it easy to get through to this surgery by phone compared with a CCG average of 85.3% and a national average of 74.4%.
- 93% found the receptionists at this practice helpful compared with a CCG average of 89.8% and a national average of 86.9%.
- 80.6% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 70.9% and a national average of 60.5%.
- 91.8% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 89.7% and a national average of 85.4%.
- 88.6% said the last appointment they got was convenient compared with a CCG average of 94.2% and a national average of 91.8%.
- 70.4% describe their experience of making an appointment as good compared with a CCG average of 82.3% and a national average of 73.8%.
- 48% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 68.3% and a national average of 65.2%.
- 53% feel they don't normally have to wait too long to be seen compared with a CCG average of 63.5% and a national average of 57.8%.

The practice had introduced a sit and wait service, where patients could come into the practice at specified times and wait to be seen on that day. This reduced the amount of time that patients had to wait to get an appointment but did mean that patients had to wait in the practice until it was their turn and times would be dependent on how busy the practice was that day.

We spoke to four patients and a member of the patient participation group. All of the patients were using the sit and wait service and one of them was a temporary resident on holiday. Patients told us that they were happy with the care provided by the GPs but they used the sit and wait service as they found it difficult to get routine appointments. One patient identified that they found the sit and wait service difficult with young children who were feeling ill.

The practice used the family and friends test to gather information and feedback from patients. The practice had received a lower than average level of patient satisfaction in the last two months. Results for July indicated that there were 39 respondents to the survey and 68% of respondents said that they would be likely to recommend the practice to their friends and family. A total of 13% said that they would be very unlikely to recommend the practice. The key area of dissatisfaction was the length of time that patients had to wait to be seen as part of the sit and wait service, especially during the summer months when there were a high number of holiday makers using the practice. The practice had provided a leaflet to patients about alternative services that could be used in the area for minor injuries.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received six comment cards which were all positive about the standard of care received and the pleasant, friendly manner of staff. Patients commented positively about the sit and wait service and acknowledged the additional pressures faced by practice during the holiday season due to the number of temporary residents that came to the area.

Summary of findings

Areas for improvement

Action the service **MUST** take to improve

- The cleaning cupboard used for storing cleaning products as well as keys must be secured to prevent unauthorised access.

Action the service **SHOULD** take to improve

- Ensure that all staff where relevant receive updated training in key areas such as infection control and health and safety.
- Continue to monitor and improve access to patient appointments and publicise the times of extended hour's surgeries to patients.

Swanage Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Swanage Medical Practice

Swanage Medical Practice is located at Station Approach, Swanage, Dorset, BH19 1HB. The practice has a patient population of 11667 and is the only GP practice in Swanage. It is located in the centre of a busy seaside town and the practice population increases significantly during the summer months due to holiday makers. The practice has a predominantly older population with 53.1% of patients being over the age of 65.

The practice has ten GP partners and two salaried GPs. Seven GPs were male and five were female. Other practice staff included practice nurses, a health care assistant, a practice manager and teams of administration and reception staff. The location consists of ten consultation rooms and six treatment rooms. The district nursing team has its base at the practice.

The practice is a research practice with GPs involved in medical research. The premises are owned by the GP partners.

The practice is open between 08.30am and 1pm and 2pm to 6.30pm Monday to Friday. The practice offered some extended hours appointments on some Monday and Wednesday evenings and alternate Saturday mornings but the timings of these appointments were not publicised in

the practice, on the practice information leaflet or website. During the period late July to mid September appointments for holidaymakers and visitors were held Monday to Friday at 1.50pm until all patients had been seen. These appointments were 'sit and wait' services. In addition there were 'sit and wait' appointments for patients registered with the practice on weekday mornings between 9am and 10.30am and weekday afternoons between 3pm and 4pm.

The practice has a personal medical services (PMS) contract, which is a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract.

The practice GPs had opted out of providing their own out of hours care and out of hours care was provided by South West Ambulance Service via the NHS 111 system.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme in order to assess and rate the practice under the Health and Social Care 2008 (Regulated Activities Regulations 2014).

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 August 2015. During our visit we spoke with a range of staff including, GPs, nurses, healthcare assistants, management and administration staff and spoke with

Detailed findings

patients who used the service. We observed how people were being cared for and reviewed policies, procedures and treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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)

Are services safe?

Our findings

Safe track record and learning

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

There was an open and transparent approach and a system in place for reporting and recording significant events. Patients affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff that we spoke with knew how to report a significant event and told us they would inform the practice manager of any incidents. We reviewed 15 significant events that had occurred in the last 12 months.

We reviewed safety records and incident reports and minutes of meetings where significant events were discussed. Lessons were shared to make sure action was taken to improve safety in the practice and action taken was recorded on the significant events record. For example, we reviewed an incident where a patient consultation had been recorded in the wrong patient's record. We saw that learning from this event included a reminder to check the patient's date of birth during the consultation. Information had been circulated to GPs and a record that the information had been acknowledged was retained. Staff told us that after a recent significant event where a patient collapsed, staff had reviewed the procedures used to confirm that all staff had acted appropriately and that procedures had been followed.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation. Local requirements and policies, including a whistleblowing policy were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.
- Staff received training in safeguarding adults and children and further training in safeguarding children level three was booked to take place on 24 November 2015. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, consulting rooms and treatment rooms, advising patients that nurses would act as chaperones, if required. There was a chaperone policy available and staff who acted as chaperones had undertaken chaperone training on 15 April 2015. The practice policy indicated that administration staff who acted as chaperones should not be left alone with the patient. This had been risk assessed and the risk assessment indicated that administration staff who acted as chaperones did not need a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. The health and safety policy available for staff had been updated in 2013. Health and Safety meetings were held every three months and minuted. The practice had up to date fire risk assessments and regular fire drills were carried out. Fire safety equipment had been checked in March 2015 and clinical equipment was checked to ensure it was working properly. Portable electrical appliances had been tested in June 2015. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as a risk assessment for the management of legionella.
- The practice had a system in place for ensuring that staff received alerts from the Medical Healthcare Products Regulatory Agency (MHRA).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be visibly clean and tidy. A practice nurse was the infection control lead and liaised with the local infection prevention teams to

Are services safe?

keep up to date with best practice. There was an infection control protocol in place and staff had received training in infection control but the staff training matrix indicated that this training should have been renewed.

- Infection control audits had been completed at least every six months with the latest audit on 25 August 2015 and we saw evidence that action was taken to address any improvements identified as a result.
- All equipment used for minor surgery was either single use or sent to an external provider for sterilisation.
- Comprehensive policies and procedures for contract cleaning staff were available. Cleaning schedules were in place that were completed on a daily basis. There were systems in place to audit contract cleaning. The cleaning cupboard was used for storing cleaning products as well as keys. We found the door was bolted on the outside and marked as private, which meant that it was less accessible young children but did not prevent unauthorised access.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security).
- Nurses administered vaccinations using Patient Group Directions, signed by GPs and the health care assistant administered vaccinations using Patient Specific Directions. Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Patient Specific Directions are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- Medicine stock checks were completed monthly and there was record of these checks. Regular medicines audits were carried out with the support of the local clinical commissioning group pharmacy teams to ensure the practice was following best practice guidelines for safe prescribing.
- The practice was an outlier for providing a particular medicine and had reviewed this information to identify which GPs were prescribing higher levels of the medicines and taken steps to reduce the prescribing rate when possible.

- Prescription pads were securely stored and there were systems in place to monitor their use.
- We looked at three recruitment files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However we noted that the practice protocol required that two reference requests were needed to as confirmation of satisfactory conduct in previous employment; one of the files we reviewed had only one reference. The practice explained that the reason was because the staff member had previously been employed at the practice.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system in place for all the different staffing groups to ensure that enough staff was on duty and administration staff were trained to cover each other's tasks during periods of absence like holidays.

Arrangements to deal with emergencies and major incidents

Consulting rooms and treatment rooms had panic buttons in place that staff pressed to summon assistance in an emergency and a back-up system was in place using an alert system on the practice computers. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator (used in cardiac emergencies) available on the premises and oxygen with adult and children's masks. There was a first aid kit and accident book available and we saw that where a member of staff had been injured action had been taken to prevent recurrence. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage and copies of the plan were held securely off site so that they could be accessed if the building could not be used. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. We were told that staff received guidance by e-mails and discussed updated guidance at team meetings but there was no single system in place to ensure distribution of NICE guidance to all staff and to record action taken as a result of the implementation of new guidance. Nurses carrying out vaccinations had links to the vaccination guidance Green book on their computer desktops. All patients had been allocated a named GP and GPs had personalised lists.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. GPs each led in specialist areas of QOF and GPs held monthly meetings that were minuted, to discuss performance against QOF. Current results were 96.3% of the total number of points available which is higher than the national average of 94.2%. Data from 2013/ 2014 showed;

- Performance for diabetes related indicators was predominantly higher than the national average. For example, the percentage of patients with the diabetes, on the register whose last measured total cholesterol (measured within the last 12 months) was 5mmol/l or less was 83.54% compared to the national average of 81.6%.
- The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding period 1 September to 31 March 2014, was 100%.
- The percentage of patients with hypertension having regular blood pressure tests was 82.86% which is similar to the national average of 83.11%.

- Performance for mental health related indicators was better than the national average, For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive agreed care plan documented in the record, in the preceding 12 months was 100% compared to the national average of 86.04%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 84.24% compared to the national average of 83.82%.

The practice had a named person who led on diabetes management. They had completed additional training and linked in with diabetes leads within the clinical commissioning group. The lead indicated that they had a high number of patients with diabetes and they proactively sought to diagnose patients.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been 24 audits completed in the last two years, these included records checks that were repeated on a set basis to identify patients who required health or medicine reviews, tests or treatments. For example, the practice completed a weekly record review to identify patients that were diagnosed with depression in order to check whether they needed to be reviewed and completed a records search every six months to identify patients who were deficient in vitamin B12 but had not had any vitamin B12 injections within the last five months.

The practice had reviewed data on the high level of attendances at the local hospital and a breakdown of data indicated that this was high because it included those patients that attended hospital for routine tests. The practice participated in applicable local audits, accreditation and peer review. The practice was an accredited research practice and patients were given a leaflet about the laws and ethics of using patients' information for research.

Older patients who presented with falls injuries automatically had their blood pressure monitored to see if this was a factor in their accident. The practice supported patients who were experiencing poor mental health to take their medicines appropriately by reviewing their conditions and prescribing their medicine on a weekly basis. The practice held a register of patients who were homeless.

Are services effective?

(for example, treatment is effective)

Information about patients' outcomes was used to make improvements for example; the practice had held multi-disciplinary meetings with social services to address the issue of social isolation within the patient population.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had a low staff turnover and systems were in place to provide cover for staff during holidays and periods of absence. Administration staff were trained to cover each other's tasks to cover periods of absence.
- The practice had an induction programme for newly appointed non-clinical and clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. All staff had access to a staff handbook which was available on the practice computer system and a copy of the staff handbook was given to new members of staff.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included induction training and on-going support, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. We noticed that some training for some staff was identified on the staff training matrix as being required annually and had not been updated. For example, a member of staff had completed training in health and safety awareness on 13 March 2014 and this had not been updated. Staff had access to and made use of e-learning training modules and in-house training. Staff were supported to attend meetings and updates that were relevant to their roles, for example, the lead nurse indicated that she attended meetings with other local practice nurses every three months and the healthcare assistant had been supported to attend training to provide some immunisations in order to support nurses.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand, and meet the range and complexity of people's needs, and to assess and plan on-going care and treatment. This included when people moved between services, for example when they were referred, or after discharge from hospital. Patients who had been booked for urgent hospital appointments were given an advice slip by the GP asking them to contact the practice if they had not been seen by the hospital within two weeks. Additionally administration staff generated a report to identify patients who had been referred urgently and had not received an appointment. We saw evidence that multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated.

Information for people who were receiving end of life care, such as their wishes around do not resuscitate was shared with out of hours services and end of life care was managed in accordance with the Gold Standards Framework.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out appropriately. The process for seeking consent was monitored to ensure it met the practices responsibilities within legislation and followed relevant national guidance. GPs had completed training in the Mental Capacity Act 2005 and other staff had completed this as part of safeguarding training. The practice asked patients to take part in clinical research and the research project was discussed with patients in detail. GPs identified

Are services effective?

(for example, treatment is effective)

that they talked to the patients and explained what the research involved and this usually took about 20 minutes. Patients were also given information about research ethics to take away and consider.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients receiving end of life care, carers, those who were vulnerable or on the child protection register, those at risk of developing a long-term condition and those requiring advice on weight loss, smoking and alcohol cessation. All patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the last 12 months. Patients who needed additional support were signposted to relevant services.

The practice had a blood pressure machine in an area of the waiting room and patients were supported to take their blood pressure. GPs had provided education events to patients on breast cancer, cardiology and prostate cancer.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 82.44%, which was comparable to the national average of 81.88%. There was a policy to send letters to recall patients to attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given to under two year olds were in line with CCG and national

averages and immunisation rates ranged from 90% to 98.9%. However immunisation rates for five year olds were significantly lower than the national averages and ranged from 51.8% to 68.2% compared to the national range of 89.9% to 96.4%. The practice told us that they proactively identified children who had not received pre-school immunisations and also followed up on those patients who did not attend for immunisation clinics. We were later provided with data that showed that these had improved to 90%.

Flu vaccination rates for the over 65s were 76.68%, and at risk groups were 54.07%. These were above national averages. Separate flu clinics were operated during the autumn months.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, patients over the age of 75 and health checks for patients with asthma, chronic obstructive pulmonary disease and reviews for patients with mild cognitive impairment who may have dementia. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice provided a quarterly newsletter for patients and included information about support groups and services available. The practice newsletter for March and June 2015 provided information to patients about local sporting events including walking for health groups.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that patients were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations but that conversations taking place in some rooms could be overheard. We saw signs indicating that chairs should not be placed in some areas of the waiting room that were close to consultation rooms so that patient consultations could not be heard by patients who were waiting for appointments. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Staff received training on managing patient's confidentiality and signed a confidentiality agreement. This procedure was extended to contractors who were going to be working at the practice for a significant period of time who may overhear information. For example, we saw that flooring contractors had signed a confidentiality agreement in June 2015.

Patients told us that signage to identify consultation rooms was confusing for some patients and that they were not always sure which room they were required to go to when called for their appointment.

All of the six patient CQC comment cards we received were positive about the service experienced. We spoke with a member of the patient participation group (PPG) and four patients on the day of our inspection. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients indicated that unavailability of routine appointments was their only concern.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 91.9% and national average of 88.6%.
- 90.9% said the GP gave them enough time compared to the CCG average of 89.9% and national average of 86.8%.
- 98.9% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.9% and national average of 95.3%
- 88.4% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89.2% and national average of 85.1%.
- 94.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.3% and national average of 90.4%.
- 93% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 89.8% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received identified that despite being under pressure to see a high volume of patients, GPs took time to listen to patients and discuss their care.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages. For example:

- 91.6% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.1% and national average of 86.3%.
- 87.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86.1% and national average of 81.5%
- 94.8% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91.7% and national average of 89.7%.

Are services caring?

- 91.7% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87.4% and national average of 84.9%

Staff told us that translation services were available for patients who did not have English as a first language. The practice provided care to patients who attended a local language school that had a matron on site who had supported staff to obtain translation services. The automated check-in system was available in different languages.

Patient and carer support to cope emotionally with care and treatment

There was a practice list of all people who had been identified as carers and were being supported. For example, the practice had a named lead that had been trained to provide support to carers by signposting them to services that were available to provide additional support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their named GP contacted them by telephone and signposted them to find support services if required. Leaflets and posters were available in the waiting area to signpost patients to support and counselling services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group to plan services and to improve outcomes for patients in the area. For example, the practice had implemented an extended hours service and had made a request to the NHS local area team to extend the service by providing extended hours nurse led clinics for routine health checks such as cervical smears, asthma and diabetes checks.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- Home visits were available for older patients and patients who would benefit from these.
- There were longer appointments available for people who were vulnerable, including patients with learning disabilities.
- The practice had successfully bid for extra funding to provide an over 75's service and multi-disciplinary team meetings were held to monitor outcomes for older people. These were attended by staff from the 'Better Together Team' and a physiotherapist from the rehabilitation team.
- Patients with long-term conditions were recalled for annual reviews and where patients required multiple reviews for different conditions; these were amalgamated into one appointment. The practice employed a nurse who also specialised in cardiac care to manage and monitor the care of patients who had a history of stroke or coronary heart disease.
- The practice had a named lead who was trained to support patients who were experiencing poor mental health, including dementia and the practice referred patients to support services such as 'Steps to Wellbeing' and also held drug and alcohol rehabilitation clinics at the practice.
- Two GPs provided family planning services to patients either by appointment or during clinics that were held on a weekly basis.
- The practice provided a range of online facilities for patients such as appointment bookings, repeat prescriptions and access to some summary information from their care records.

- There were accessible toilet facilities, hearing loop and translation services available.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.30am to 1pm every morning and 2pm to 6.30pm daily. Extended hours surgeries were offered on some Monday and Wednesday evening and alternate Saturday mornings but there were no timings publicised to patients. Urgent appointments were also available for people that needed them and the practice provided telephone appointments to improve efficiency. There were no routine appointments available at the practice between 26 August and 21 September 2015 but the practice did have appointments for patient who needed urgent treatment available the next day and additional appointments for patients who only wanted to see a female GP available on 8 September 2015.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages in some areas but patients told us that whilst it was difficult to get a routine appointment with a named GP they were able to get urgent appointments when they needed them. For example:

- 70.9% of respondents were satisfied with the practice's opening hours compared to the CCG average of 78.8% and national average of 75.7%.
- 81.1% of respondents said they could get through easily to the surgery by phone compared to the CCG average of 85.3% and national average of 74.4%.
- 70.4% of respondents described their experience of making an appointment as good compared to the CCG average of 82.3% and national average of 73.8%.
- 48% respondents said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68.3% and national average of 65.2%.

Patients commented that they were unable to get a routine appointment with their GP and had to use the 'sit and wait' service. The practice was under particular pressure during the summer months due to a high volume of temporary visitors to the area. The practice had identified that patient satisfaction was lower than local and national averages

Are services responsive to people's needs?

(for example, to feedback?)

and identified that those concerns raised by patients who have had to wait more than 15 minutes for an appointment may refer to those patients who attend the 'sit and wait' service.

In response to the increased demand for appointments, the practice operated 'sit and wait' services between 9am and 10.30am and between 3pm and 4pm on weekdays. There was also a separate 'sit and wait' clinic for temporary residents, which operated during the summer months in order to reduce the impact of the high number of holiday makers who required treatment during this time.

The practice were assessing the possibility of implementing minor ailments and triage clinics, which would be run by nurses and would also operate on a sit and wait basis. The practice had completed an audit of time lost due to patients failing to attend appointments and initial findings indicated that 655 patients had failed to attend appointments between April and June 2015 and staff would publish updated figures on September's newsletter. The practice telephoned patients to remind them about some appointments and this appeared to have reduced the time wasted because people did not attend for their appointments. The practice provided information to patients about alternative services that could be used to provide treatment to patients. The practice issued a newsletter to patients every three months and this included information about the 'sit and wait' service and other services in the area such as pharmacies and the minor injuries unit.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website and a summary leaflet about how to complain was available. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 15 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. All complaints received by the practice were recorded on a separate spreadsheet and if required discussed at weekly clinical meetings and other staff meetings. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a member of the PPG told us that a patient had complained about not being able to hear when they were called for their appointment and the practice had responded by having a hearing loop fitted. Clinical staff also sent a message to reception if patients did not come into the consulting room so that they could make sure that the patient was aware that they had been called for their appointment. Complaints were discussed on a monthly basis and any significant issues would be raised at weekly clinical meeting but weekly clinical meetings were not minuted. Some but not all learning outcomes were recorded. A full review of complaints was completed annually to identify trends.

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 documented clear vision which was to have healthy people living healthy lives in healthy communities. The practice had documented strategic ambitions in order to help it to achieve its vision and these included providing high quality, safe, professional primary health care and general practice services to their patients and preventing ill health by focussing on prevention, promotion and early intervention in both physical and mental health.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. There were signs identifying which staff had lead roles in areas such as safeguarding, health and safety, infection control and fire safety.
- Practice specific policies were implemented and were available to all staff and a staff handbook was available on the computer desktop.
- There was a comprehensive understanding of the performance of the practice and areas such as lower than expected child immunisation rates were addressed.
- There was a programme of continuous clinical and internal audit in place, which was used to monitor quality and to make improvements.
- Some areas were less robust such as for managing risks for Chemicals Hazardous to Health and ensuring up to date training arrangements

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time

to listen to all members of staff. The practice provided a buddy system with more experienced GPs buddying younger GPs to support learning and mentoring. Staff also had a coffee break, where they could chat informally and share learning.

Staff told us that regular team meetings were held. GPs met weekly and nurses meetings were held every six weeks and these meetings were used as a training opportunity. Not all meetings such as clinical meetings had minutes or actions recorded. Reception meetings were held on a quarterly basis. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff told us that they worked well together, felt supported by management and supported each other, for example after a recent significant event at the practice staff were able to talk together about how they were feeling.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The group had 15 members and there was a virtual PPG of about 100 members. Meetings were held every two months and minutes were sent to all members of the group including virtual members. A member of the PPG told us that the practice had been proactive in providing events such as talks for patients about dementia and diabetes. The practice held a PPG event, that members attended and there was a notice board display in the practice waiting room about the PPG and its role.

The practice had also gathered feedback from staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had recently introduced a coffee break for staff and indicated that they have taken steps to monitor and improve the work life balance of staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Family planning services	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 Premises and equipment
Maternity and midwifery services	1.All premises and equipment used by the service provider must be—
Surgical procedures	a.clean
Treatment of disease, disorder or injury	b.secure
	How the regulation was not being met: The cleaning cupboard used for storing cleaning products as well as keys must be secured to prevent unauthorised access.
	Regulation 15(1)(a)(b)