

Derby Medical Centre

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?

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 undertook a comprehensive inspection of The Derby Medical Practice on 18 November 2014.

We have rated the practice as good. We found that the practice provided an effective, caring and responsive service to patients. However improvements were required in relation to safety. There was a strong ethos of providing continuity of care and the practice maintained a personal list system in response to patient preference for this. All of the staff we spoke with were committed to providing a caring service and they all felt well supported in their roles. Patient feedback was consistently positive.

Our key findings were as follows:

- Each GP had their own personal list to ensure that patients always saw the same GP to ensure continuity of care.
- Systems were in place to ensure high standards of cleanliness and infection control and patients said the practice was always clean and tidy.

- Patients described the service they received as excellent. Staff were described as helpful, caring, supportive and respectful.
- The practice was responsive to the particular patient needs of its registered population. For example, because of the large number of students on its register, practice staff spent three days on local college sites registering students and providing them with an extensive range of health advice and literature.
- Records for the purpose of managing the practice were not always maintained.
- Some patients commented that confidential conversations at the reception desk in the waiting area could easily be overheard.

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

Importantly, the provider must:

- Assess the risk of using staff as medical chaperones who had not received a criminal record check undertaken with the Disclosure and Barring Service (DBS).

Summary of findings

- Keep records of registration checks undertaken with professional bodies for relevant staff.

In addition, the provider should:

- Provide appropriate training to non-clinical staff who act as medical chaperones.
- Ensure that performance, quality and risks are discussed and assessed on a regular basis and that records of this are kept.
- Put agreed systems in place for recording significant events and safety alerts in a consistent format in order to demonstrate what lessons have been learned, how these have been shared with staff and what action has been taken as a result.

- Put a system in place that ensures practice policies and procedures are up to date and that current and previous versions are clearly identifiable.
- Put measures in place to ensure that patients who present at the reception desk in the waiting area are not asked to divulge confidential or sensitive information which can be overheard by other patients.
- Clarify the leadership structure so that lead roles and responsibilities are clearly identifiable.

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. Although this information was not always consistently recorded, there was evidence that significant events were routinely communicated and that the lessons learned were used to support improvement. There were enough staff to keep patients safe. There were policies and procedures in place to safeguard children and vulnerable adults and staff understood their responsibilities in relation to this. The practice had not risk assessed whether a criminal record check with the Disclosure and Barring Service (DBS) was required for non-clinical staff acting as medical chaperones. Not all staff who undertook medical chaperone duties had been appropriately trained to do so.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams. Patients had a named GP which allowed for continuity of care.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with care and respect and they felt listened to and supported. Information to help patients understand the services was widely available and was easy to understand. Staff understood their roles in relation to maintaining patient confidentiality; however some patients commented that confidential conversations at the reception desk in the waiting area could easily be overheard.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patients said they could make an appointment with their own GP and that there was good continuity of care. The practice had an active patient participation group (PPG) which it met with on a monthly basis. The PPG assisted the practice in the design and distribution of an annual patient satisfaction survey. There was evidence that the practice implemented improvements to its services as a result of patient feedback. Information about how to

Good



Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities.

Are services well-led?

The practice is rated as good for being well-led. It had an ethos of providing personalised care to its patients which was set out on the practice website. The practice did not have a documented leadership structure and although most staff felt supported by management there were times they were not sure who to approach with issues. The practice had a number of policies and procedures to govern activity. The GPs had weekly and monthly meetings but it was not evident from the notes that performance, quality and risks were routinely discussed. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and regular performance reviews. Staff attended 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. The practice offered proactive, personalised care to meet the needs of the older people in its population including weekly visits to the local nursing home. Staff at the nursing home had a direct dial telephone number so they could bypass the practice's public telephone system and gain quick access to GP advice. The practice provided flu vaccinations to people at home who were house bound. The practice identified older people who were at risk of hospital admission to ensure they had a care plan. The practice worked with multi-disciplinary teams to ensure that people received high quality end of life care.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. All these patients had structured annual reviews to check their health and medicine needs were being met. Where patients had more than one long term condition all of their needs were reviewed in one longer appointment to avoid multiple visits. The practice worked closely with other health professionals, to ensure these patients' needs were met. For example, there was a dietician who ran a clinic once every two weeks at the practice. All new diabetic patients were seen in this clinic. There was also a chiropody service provided on the practice premises that diabetic patients could be referred to.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered contraception advice and pregnancy counselling for 14 to 22 year olds as well as a comprehensive family planning service. This included contraceptive pill, contraceptive injections, advice on barrier methods and fitting of caps, inter-uterine fitting and checks, general contraceptive advice and emergency contraception. The practice also provided basic screening for sexually transmitted diseases. The practice met regularly with the health visitor and systems were in place for identifying and following-up children identified as at risk. All staff had received training on safeguarding children and were aware of their roles and responsibilities in relation to this.

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 made sure the services it offered were accessible, flexible and offered continuity of care. This included the operation of personalised lists and extended opening hours on Monday evenings. The practice was proactive in offering on line services as well as a full range of health promotion and screening which reflected the needs for this age group. The practice had a large number of students on its register. At the start of each academic year practice staff spent three days on local college sites registering students and providing them with an extensive range of health advice and literature.

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 had a designated GP who provided support to patients with a learning disability and carried out their annual health checks. The practice also had a large number of patients who were registered blind and as a result had ensured that health promotion messages were made audible in the waiting area via the TV screen. Patients were also called to their appointment using an audible system.

The practice was situated in new purpose built premises on the first floor of a shopping centre in Epsom. There were wider lifts for wheelchair users who required access from other floors. There was a call bell system so that wheelchair users could request assistance through the front door to the practice. There was also a toilet that was accessible to disabled people and the practice had an induction loop for patients who were hard of hearing. The practice had access to translation services for patients who did not have English as a first language.

Staff knew how to recognise signs of abuse in vulnerable adults and children and who to report their concerns to. Training records showed that all staff had received training on safeguarding vulnerable adults.

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). The practice

Summary of findings

had good access to telephone advice from the community mental health teams and made regular referrals to local NHS psychological therapy and counselling services. The practice also signposted patients to various support groups and private counselling services.

Summary of findings

What people who use the service say

We reviewed 28 comment cards where patients and members of the public shared their views and experiences of the service. All of the comments we received were very positive. Patients described the care and treatment they received as excellent. They said that staff were caring and respectful. They said they felt the surgery was always clean and tidy. Some patients commented that confidential conversations at the reception desk in the waiting area could be overheard by other patients which they felt compromised their privacy.

We reviewed the most recent data available for the practice on patient satisfaction. Data for the 2013 national GP survey showed that the practice performed above average in a number of areas. For example 91 per cent of respondents described the overall experience of the practice as fairly good or very good and 95 per cent of respondents stated that the last time they saw or spoke to a GP the GP was good or very good at treating them with care and concern. However, the proportion of patients who stated that in the reception area other patients cannot overhear was significantly below average.

Areas for improvement

Action the service **MUST** take to improve

- Assess the risk of using staff as medical chaperones who had not received a criminal record check undertaken with the Disclosure and Barring Service (DBS)
- Keep records of registration checks undertaken with professional bodies for relevant staff.

Action the service **SHOULD** take to improve

- Provide appropriate training to non-clinical staff who act as medical chaperones.
- Ensure that performance, quality and risks are discussed and assessed on a regular basis and that records of this are kept.

- Put agreed systems in place for recording significant events and safety alerts in a consistent format in order to demonstrate what lessons have been learned, how these have been shared with staff and what action has been taken as a result.
- Put a system in place that ensures practice policies and procedures are up to date and that current and previous versions are clearly identifiable.
- Put measures in place to ensure that patients who present at the reception desk in the waiting area are not asked to divulge confidential or sensitive information which can be overheard by other patients.
- Clarify the leadership structure so that lead roles and responsibilities are clearly identifiable.

Derby Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a GP Specialist Advisor.

Background to Derby Medical Centre

The practice is situated in the centre of Epsom and provides general medical services to approximately 13,000 patients. There are eight GPs, four male and four female. The practice also employs four practice nurses, one health care assistant and a phlebotomist. Opening hours are Monday to Friday 8.15am to 6.15pm and Monday 6.30pm to 8pm. The practice provides a range of services to patients including annual checks for chronic disease management, weight management advice, family planning, immunisations and cervical screening.

The practice has a slightly higher than average number of registered patients over the ages of 65, 75 and 85. The percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

The CQC intelligent monitoring placed the practice in band 2. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP

practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the Surrey Downs Clinical Commissioning Group (CCG), NHS England and Healthwatch Surrey to share what they knew.

During our visit we spoke with a range of staff including, the GPs, the practice manager, the practice nurses, administrative staff and receptionists. We examined practice management policies and procedures. We spoke with representatives from the practice's patient participation group. We also reviewed 28 comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

To get to the heart of patients' experiences of care 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

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We looked at significant event and complaint records for the last year. We saw that the practice had an annual meeting to review complaints and that learning points were identified and shared appropriately. The GPs and practice manager told us that significant events were discussed as they arose and at partners meetings. They were all able to tell us about examples of significant events that had arisen, the lessons learned and the actions taken as a result.

Learning and improvement from safety incidents

We looked at significant events records for the last year and noted that GPs were recording significant events in a variety of different formats. It was not always clear from the records how and whether learning points had been shared or what action had been taken as a result. We were told that significant events were discussed as they arose and at partners meetings and all the GPs were able to describe recent examples and the action that had been taken as a result. However, there were no records of the meetings to show that this was the case.

The practice had a system for ensuring all external safety alerts were responded to appropriately. All incoming alerts were reviewed by the practice manager who ensured that information was disseminated to relevant staff and that appropriate action was taken. However, there were no records to confirm this was the case.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures in place to safeguard children and vulnerable adults which were easily accessible to all staff. The practice had a dedicated GP appointed as the lead for safeguarding children and vulnerable adults. They had been trained to enable them to fulfil this role and could demonstrate they had been trained to level 3 for safeguarding children. We saw evidence that training on safeguarding children and vulnerable adults had been cascaded to all staff. The staff we spoke with

were aware of their roles and responsibilities in relation to safeguarding in general practice. They were able to describe the types of signs and symptoms of potential abuse and knew who to contact if they had concerns.

GPs used required codes on their electronic patient case notes to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

The practice had a chaperone policy in place and the details of how to access this service were clearly displayed. This allowed patients to have someone else present for any consultation, examination or procedure if they wished. This could be a family member or friend or a formal chaperone from the practice staff. However, this included administrative and reception staff who had not been formally trained to undertake these duties.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were arrangements in place for ensuring medicines were kept at the required temperatures. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. The practice had a system in place for disposing of expired and unwanted medicines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Feedback from patients showed they thought the practice was always clean, tidy and hygienic. The practice had a lead for infection control who had experience and training that enabled them to provide advice on the practice infection control policy and carry out

Are services safe?

staff training. We were told that not all nursing staff had up to date training in infection control and that this was in the process of being arranged through the clinical commissioning group (CCG). We saw that all staff had recently completed in-house training on hand washing. The practice had undertaken an audit of infection control and there was evidence that improvements had been implemented as a result of the findings. For example, the practice now had up to date records on the hepatitis B vaccination status for all staff.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to implement control of infection measures. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a system in place for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice had regular checks undertaken in order to reduce the risk of infection to staff and patients.

Equipment

We saw that staff had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. All equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

Staffing and recruitment

The staff records we looked at showed that most of the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, and criminal records checks via the Disclosure

and Barring Service (DBS) for newly appointed nursing staff. We were told that the practice checked registration with the appropriate professional body for relevant staff, however this was not always recorded. The practice did not undertake DBS checks for administrative and reception staff. We noted these staff sometimes undertook medical chaperone duties which could involve them being left alone with patients.

Staff told us there was enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. The GPs told us that they had a system in place for covering each other when they were away which meant they rarely had to employ locums.

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. The practice had undertaken an up to date health and safety risk assessment and undertook regular checks of the building. The practice also had a lead for health and safety and a health and safety policy.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. We saw evidence that all staff had received up-to-date training in basic life support appropriate to their role. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines were available in the treatment rooms and all GPs and nurses knew of their location. We saw that processes were in place to check emergency medicines were within their expiry date and suitable for use.

The practice had arrangements in place to deal with foreseeable emergencies. We saw that there was a comprehensive and up-to-date business continuity plan in place. The plan outlined the arrangements to deal with foreseeable events such as loss of energy supplies, severe weather, loss of the computer system and essential data and fire.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. They told us that new guidelines were discussed at weekly practice meetings. The practice used a referral management system developed by the clinical commissioning group (CCG) which helped ensure all referral were appropriate. Regular audits were undertaken by the CCG and the practice.

The GPs told us they each took a lead in specialist clinical areas such as diabetes, prescribing and sexual health. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. They told us that all of the GPs met every morning to help facilitate knowledge sharing and discuss best practice. The practice nurses also attended the daily meeting if they needed guidance or advice on specific issues.

Management, monitoring and improving outcomes for people

The practice showed us four clinical audits that had been undertaken over the last year. These were discussed with the GPs and we were provided with examples where changes to clinical practice had been made as a result. The GPs told us that audits were often linked to clinical needs, medicines management information from the CCG and information for educational events. The GPs told us that they shared and discussed the results of the audits at their weekly practice meetings. The results of audits were also stored on the practice's clinical information system so that all GPs had access to them.

The practice used the information they collected for the quality and outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The practice met regularly to review its performance against the QOF and to agree what measures it needed to put in place to achieve the targets and improve outcomes for patients. For example, the practice undertook an audit of registered patients to ensure that all patients who should be were on the learning disability register. This ensured they received an annual medical check.

There was evidence that the practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. For example, the practice regularly reviewed referral information from the CCG to ensure it referrals were appropriate. Comparative data for the CCG was also used to analyse the practices use of medicines.

Effective staffing

The records we looked at showed that all administrative and reception staff completed an induction which included an introduction to the practices policies and procedures, health and safety. It also included role specific training requirements. We saw that administrative staff had also undertaken in-house training on safeguarding children and vulnerable adults and hand washing. We saw that nursing staff had completed training in a number of areas which included diabetes updates, travel health and childhood immunisations.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff had appraisals in the last year which identified key strengths, areas for improvement and learning and development needs. All the staff we spoke with felt well supported by the GPs and managers in their roles. They told us they felt they had sufficient access to training opportunities.

Working with colleagues and other services

There was evidence that the practice worked closely with other organisations and health care professionals. The community nurse met with the GPs every week to discuss any unplanned hospital admissions and to identify patients who required following up after discharge from hospital. The practice had quarterly multi-disciplinary meetings with the community nursing service, staff from the local hospice and the CCG lead for end of life services to discuss the needs of complex patents and those with end of life care needs.

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used electronic systems to communicate with other providers. Blood test and x-ray results, clinical letters from the local hospital including discharge summaries and reports from the Out of Hours providers were all received electronically. The practice had systems to provide staff with the information they needed. Staff used an electronic patient management system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All of the GPs we spoke with were aware of their responsibilities in relation to obtaining consent to care and treatment. We saw that the practice had a policy of obtaining written consent. For example, written consent for minor surgery and contraceptive implants was recorded and scanned in to patients' electronic notes. The GPs we spoke with were aware of the Mental Capacity Act 2005

(MCA) but were not fully conversant with their duties in fulfilling it. They told us that training for the practice on the MCA for the practice was in the process of being planned by the CCG.

Health promotion and prevention

The practice required all new patients offered registering with the practice to complete a comprehensive health questionnaire so that their individual health needs could be identified. Newly registered patients were offered a health check and the practice also offered NHS Health Checks to all its patients aged 40-75. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over. The practice nurses provided a smoking cessation and weight control advice and screening services including cervical screening and chlamydia testing. There was a range of patient literature on health promotion and prevention available for patients in the waiting area. The practice website provided patients with health advice and information about healthy lifestyles.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national 2013 GP survey, CQC comments cards and the results of a survey undertaken by the practice during 2013-2014 of 455 patients. We also spoke with representatives from the practice's patient participation group (PPG). Feedback from patients showed they were very satisfied with how they were treated by clinical staff. Patients commented that they were treated with care, courtesy and respect. The PPG representatives told us that clinical staff were caring and compassionate. The proportion of respondents to the national GP patient survey who stated that the last time they saw or spoke to a GP at the practice, the GP was good or very good at treating them with care and concern was 95 per cent. The majority of respondents to the practice's own survey rated the helpfulness of staff as excellent or good.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room and that doors could be locked if necessary. We observed that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There were curtains in place around the examination couches and blinds at the windows. The staff we spoke with were familiar with the practice's confidentiality policy and told us when discussing patients they ensured that confidential information was kept private. However, all sources of patient feedback identified concerns about being able to overhear private conversations at the reception desk in the waiting area. For example, the proportion of respondents to the national GP survey who stated that in the reception area other patients cannot overhear was significantly below average. Feedback from the comments cards, the

practice's own survey and the PPG representatives we spoke with highlighted similar concerns. The practice was aware that this had been raised as an issue for patients and the staff we spoke with told us they took patients to a private room if necessary and that they were of the need to protect patient confidentiality.

Care planning and involvement in decisions about care and treatment

The patient feedback we received and the results of surveys showed that patients were positive about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 80 per cent of respondents to the GP patient survey stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care. Comments we received indicated that patients felt that they were given time, that they were listened to and that things were explained.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

All the patient feedback we received showed that patients were positive about the emotional support provided by the practice and rated it well in this area. The GPs and practice nurses were consistently described as caring, supportive and reassuring. The GPs made regular referrals to local NHS psychological therapy and counselling services. The practice also signposted patients to various support groups and third sector organisations including bereavement counselling services and marriage guidance.

There was a wide range of patient literature available in the waiting area which sign-posted patients to a number of support groups and organisations.

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 people's needs. The practice had a patient participation group (PPG) which met every six weeks with the practice manager and GP representatives. We met with members of the PPG who told us that the practice listened to patient views and was responsive to their needs. We were provided with examples of how the practice had implemented improvements as a result of feedback from the PPG. For example, the practice had invested in a display screen in the waiting area which provided patients with a range of health information and provided a visual and audio system of calling patients in to see the GP. Lighting in the waiting area had also been improved.

The practice was able to demonstrate that it understood the needs of its registered population and had organised its services to meet these needs. For example, to meet the needs of its student population practice staff spent three days on local college sites at the start of every academic year registering students and providing them with an extensive range of health advice and literature. The GPs regularly communicated with college staff about the particular health needs of students and when these needed to be taken in to consideration, for example during exam periods.

The practice also had 56 blind patients on its register who lived in supported housing. In response to their needs the practice had ensured that its display screen had audible health promotion messages and an audible and visual call system for patients in the waiting area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning and delivery of its services. It was situated in purpose built accommodation inside a shopping centre and could be accessed by lifts or stairs. The doors to the practice were not automatic but disabled patients and wheelchair users were able to summon assistance from the reception staff by pressing a buzzer. The reception desk was lower at one end for wheelchair users and there were toilet facilities for those patients with a disability. The practice had a hearing induction loop which could be used in patient consultations for those who were hard of hearing. The practice had access to telephone translation services for patients whose first language was not English.

Access to the service

Appointments were available from 8.15am to 6.15pm on weekdays. The practice had extended hours on a Monday from 6.30pm to 8.00pm by appointment only. Most of the practice's appointments were for advanced booking and there are a limited number kept available for urgent, "on the day" appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent and routine appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answer phone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in leaflets and on the website.

The national GP survey showed that 80 per cent of patients were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours. The proportion of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment was above the national average.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and 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 and was on display for the public to see on the notice board. Details of how to complain were also set out on the practice website. We looked at the complaints records and responses to patients over the last twelve months. The practice had received 17 complaints during this period. There was evidence that complaints were discussed at practice meetings and at an annual review meeting. We saw that action had been taken as a result of complaints and that learning was implemented.

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 ethos of providing a personalised GP service whereby each patient always saw the same GP to ensure continuity and care. This ethos was clearly outlined on the practice website. All the GPs we spoke with were able to articulate their understanding of the practice ethos. The practice had a clear set of objectives which were set out in its statement of purpose.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at six of these policies and procedures. However, not all of the policies we looked at had version numbers or annual review dates.

The practice held weekly clinical meetings for the GPs and there were monthly partners meetings. Minutes were kept for the monthly partners meetings and when we looked at these it was not evident that performance, quality and risks such as significant event and complaints were routinely discussed. We were told that significant events were discussed at the weekly GP meetings, however there were no meeting records to confirm that this was the case.

The practice used the quality and outcomes framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We were told that QOF data was regularly discussed and were provided with examples of action taken to maintain or improve outcomes.

The practice had completed a number of clinical audits and there was evidence that the results of these were shared and discussed. Learning was implemented to improve outcomes for patients.

Leadership, openness and transparency

The practice did not have a documented leadership structure and although most staff felt supported by management there were times they weren't sure who to approach with issues.

Although the practice had designated leads for particular areas, for example infection control and safeguarding, a management structure identifying these and the lines of accountability was not documented. The staff we spoke with felt clear about their own roles and responsibilities and told us they felt valued and well supported.

The GPs met weekly and all staff teams had daily or weekly meetings with their managers. Staff told us that the practice was open and transparent and that there was a no blame culture. They felt confident about raising concerns they had and that these would be listened to and acted on.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff, for example the induction, training, and whistleblowing policies. We were shown the staff handbook that was available to all staff, this included sections on leave arrangements and discipline and grievance procedures. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through its patient participation group (PPG), annual surveys and complaints. The practice ran a survey to look at the areas that the PPG had said were important to them. We looked at the practice's report on the last patient survey which provided an analysis of the results and identified areas for action. There was evidence that the practice had implemented an action plan as a result.

Staff told us they felt their views were valued and that they were involved in helping improve services and outcomes for patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and regular discussion of clinical practice. The staff records we looked at showed that appraisals happened yearly and that staff had personal development plans. Staff told us that the practice was supportive of training and they had the skills and knowledge they needed to fulfil their roles.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The practice failed to ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate. Regulation 21 (b).